UNIVERSAL CURRICULUM
Treatment of Substance Use Disorders

The Universal Treatment Curriculum for Substance Use Disorders (UTC)

Participant Manual

UTC 5

Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals

4th Edition, 2020

THE COLOMBO PLAN

DAP
Drug Advisory Programme

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Basic Level UTC Series - UTC 5

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Acknowledgments

UTC 5: Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals is part of an eight-volume training series originally developed for the U.S. Department of State Bureau of International Narcotics and Law Enforcement Affairs (INL). The publication was originally developed under contract number SAQMPD07D0116, Demand Reduction Support Services, between INL and Alvarez & Associates, with JBS International, Inc. (JBS), serving as subcontractor. Some materials in this Course were developed by JBS for Family Health International Hanoi, Vietnam) under a contract supported by the U.S. Agency for International Development. This manual has undergone several revisions under the supervision of the Colombo Plan.

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Peer Review Panel

1. *Rodrigo Portilla Huidorbro, M.P.H, ICAP II, Project Manager for Latin America and Caribbean, Colombo Plan Drug Advisory Programme, Chile*
2. *Dr. Yatan Pal Singh Balhara, Ph.D., Additional Professor of Psychiatry, National Drug Dependence Treatment Center (NDDTC) and Department of Psychiatry, All India Institute of Medical Sciences (AIIMS), India*
3. *Thirumagal, Ph.D., ICAP II, NCAC I, Independent Consultant, India*
4. *Marta Oliva, Adviser, Colombo Plan Drug Advisory Programme, Chile*
5. *Yehudith Ayala, Behavioral Health Specialist, US*
6. *Luis Diego Camacho Madrigal, Master in Clinical Psychology, Professor, Universidad de Costa Rica y la Universidad Estatal a Distancia UNED, Costa Rica*

Treatment Expert Advisory Group

1. *Bruno Bui, Foreign Affairs Officer, Bureau of International Narcotics and Enforcement Affairs (INL), U.S. Department of State*
2. *Nathalie Pannabokke, Project Director: CHILD, Colombo Plan Drug Advisory Programme*
3. *Becky Vaughn, Director, Global Center for Credentialing and Certification (GCCC), Colombo Plan Drug Advisory Programme*
4. *Dr. Mariano Montenegro, Director Colombo Plan Office for Latin America and the Caribbean, Trainer for UNODC, Latin America and the Caribbean*
5. *George Murimi, Project Manager for Africa, Colombo Plan Drug Advisory Programme*
6. *Dr. Nyein Zaw Htet Doe, Project Manager – Curriculum Development (Treatment), Colombo Plan Drug Advisory Programme*

7. *Annette-Dale Perera. Director, ADP Consultancy, UK*
8. *Goodman Sibeko MD and Ph.D., Director at International Technology Transfer Center South Africa, Cape Town, Western Cape, South Africa*
9. *Elizabeth Sáenz MD, Pediatrician, MPHDC, MMCH, Liaison Officer (UNODC-WHO Programme on Drug Dependence Treatment and Care) in Geneva, Prevention, Treatment and Rehabilitation Section, Drug Prevention and Health Branch, United Nations Office on Drugs and Crime*
10. *Abel Basutu Ph.D., Programme Management Specialist, African Union Comission, Addis Ababa, Ethiopia*

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Disclaimer

The substance use disorder treatment interventions described or referred to herein do not necessarily reflect the official position of INL or the U.S. Department of State. The guidelines in this document should not be considered substitutes for individualized client care.

4th Edition
Published 2023 - Sri Lanka

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PARTICIPANT ORIENTATION

Introduction

Welcome! This training will provide you with an overview of the basic principles of person-centered screening, assessment, treatment planning, and clinical documentation. It also will introduce in details a screening instrument, the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), and an assessment instrument, the Addiction Severity Index (ASI). You will have opportunities to practice using both of these instruments.

Course 5: *Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals* is part of a training series developed through funding from the U.S. Department of State to The Colombo Plan Drug Advisory Programme (DAP). Information about Colombo Plan can be found at http://www.colombo-plan.org.

The overall goal of the training curriculum is to reduce the significant health, social, and economic problems associated with substance use disorders (SUDs) by building international treatment capacity through training, professionalizing, and expanding the global treatment workforce. The training prepares counselors for professional certification at the entry level by providing the latest information about SUDs and their treatment and facilitating hands-on activities to develop skills, confidence, and competence.

Congratulations for taking the time to learn more about your work!

The Training

The 8 modules in this training series may be delivered over 5 consecutive days or may be offered over the course of several weeks or months. Your trainers have provided you with a specific agenda.

The learning approach for this training includes:

- Trainer-led presentations and discussions;
- Frequent use of creative learner-directed activities, such as small-group and partner-to-partner exercises and presentations;
- Reflective writing exercises;
- Periodic reviews to enhance learning retention; and
- Learning assessment exercises.

Your active participation is essential to making this a positive and productive learning experience!

Goals and Objectives for Course 5

Training goals

- To introduce participants to the different stages of the Care Pathway;
- To provide participants the key elements that affect client engagement and retention;
- To familiarize participants with the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST);
- To introduce participants to brief intervention, particularly an ASSIST-linked intervention;
- To introduce participants to the key elements of the assessment process;
- Give participants an introduction to the domains of comprehensive assessment;
- To provide an overview of the process and elements of narrative summaries and person-centered treatment planning; and,
- To introduce participants to the importance and elements of structured record keeping.

Learning objectives

Participants who complete Course 5 will be able to:

- Identify factors affecting client engagement and retention;
- Identify promising practices that may be practically implemented in your program;
- Describe the process of screening and brief intervention;
- Demonstrate ability to screen clients using the ASSIST-BI;
- Describe the process of initial assessment;
- Describe the process of comprehensive assessment;
- Identify assessment instruments for the different life areas / problems;
- List the 6 elements of a narrative summary;
- Identify the critical aspects of person-centered planning;
- List the 5 features for treatment plan objectives;
- List the 5 elements for treatment plan interventions;
- Describe how structured documentation supports effective treatment; and,
- Demonstrate beginning ability to use the Mapping Technique.

Training materials

Training materials include:

- This *Participant Manual*; and
- A notebook.

Each module of your *Participant Manual* includes:

- Training goals and learning objectives for the module;
- A timeline;
- PowerPoint slides printed three to a page spread with space for you to write notes;
- Resource Pages containing additional information or exercise instructions and materials; and
- A module summary.

The *Participant Manual* also has a glossary (Appendix A), a list of resources (Appendix B), and a list of people who are given special acknowledgment (Appendix C).

Your trainers will give you a notebook to use as your personal journal. You can use this journal in a number of ways. You can note:

- Topics you would like to read more about;
- A principle you would like to think more about;
- A technique you would like to try;
- Ways you might be able to add some of the things you're learning to your practice; and
- Possible barriers to using new knowledge.

Your trainers will also ask you to complete short writing assignments.

TAP 21 was developed in the United States to provide a common foundation on which to base training and certification of addiction professionals. The publication addresses these questions:

- What professional standards should guide counselors working with people with SUDs?
- What is an appropriate scope of practice for the field of SUD counseling?
- Which competencies are associated with positive treatment outcomes?

- What knowledge, skills, and attitudes should all SUD treatment professionals have in common?

TAP 21 can serve as a useful reference for you. Keep in mind, however, that it takes time and experience to develop counseling competence. TAP 21 represents an ideal set of goals, not a starting point. Don't get overwhelmed! You'll get there.

Getting the Most From Your Training Experience

To get the most from your training experience:

- If you have a supervisor, speak to him or her before the training begins. Find out what his or her expectations are for you.
- Think about what you want to learn from each module.
- Come to each session prepared; review the manual pages for the modules to be presented.
- Be an active participant. Participate in the exercises, ask questions, write in your journal, and think about what additional information you want.
- Speak to your supervisor (or co-workers, if you have no supervisor) after the training. Talk about what you learned to be sure you understand how the information relates to your job.
- Discuss with your supervisor or co-workers ways that you can put your learning into practice, and continue to follow up on your progress.
- Have fun!

U.S. DEPARTMENT OF STATE
MODULE 0

MODULE - 0
U.S. DEPARTMENT of STATE

Congratulations!

> As a participant in this training, you are part of a rapidly growing global community of substance use professionals

How is this global community of substance use professionals expanding?

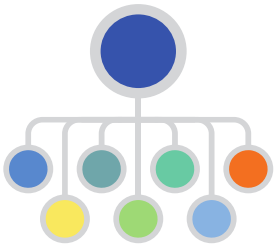
In the last decade, a growing number of people are:

- ✓ being trained
- ✓ being credentialed
- ✓ studying at universities with specialized addiction programs
- ✓ operating in the context of a larger drug control system
- ✓ adhering to science and research-based approaches
- ✓ joining professional substance use associations
- ✓ networking through professional associations

Who are the members of this global community of substance use professionals?

Individuals working worldwide in the substance use prevention and treatment fields in government, non-governmental organizations, civil society, and the private sector

Organizations that act as portals or "doorways" for individuals to join the global community



ISSUP INTERNATIONAL SOCIETY OF SUBSTANCE USE PROFESSIONALS

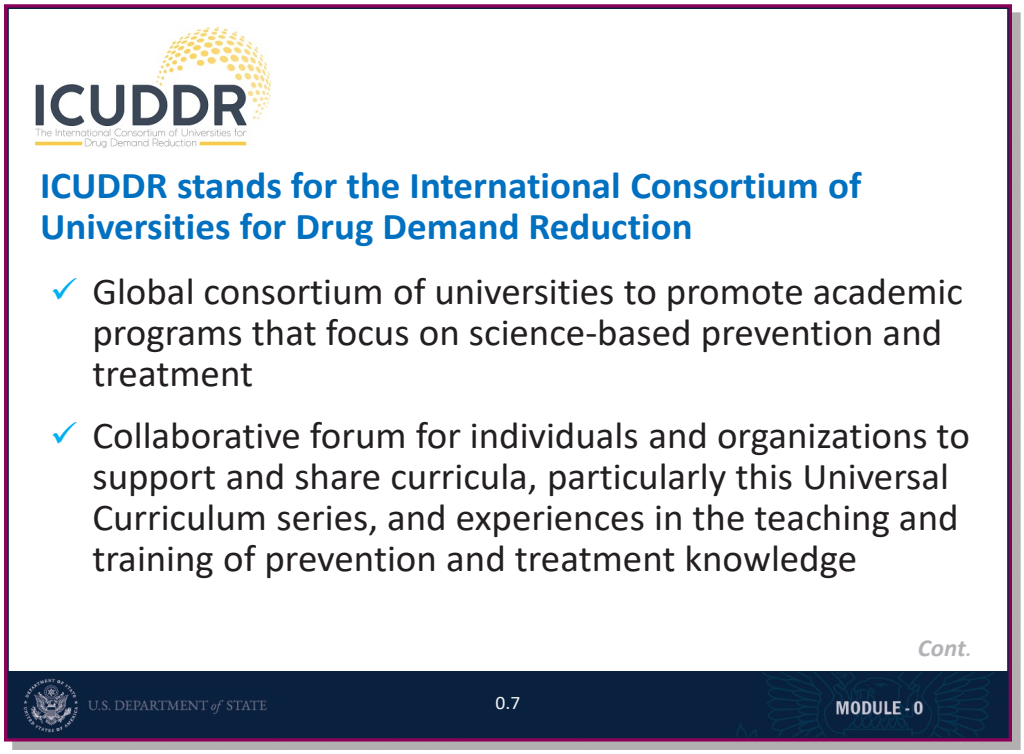
ISSUP stands for the International Society of Substance Use Professionals

- ✓ ISSUP was launched by INL in 2015 as a global, not for profit, non-governmental organization to professionalize the global prevention and treatment workforce.
- ✓ ISSUP provides members with opportunities to share knowledge, exchange experiences, and stay abreast with current research in the field

Cont.

ISSUP stands for the International Society of Substance Use Professionals

- ✓ There are more than 10,000 ISSUP members worldwide
- ✓ Join one of ISSUPs four levels of membership for free at: www.issup.net
- ✓ You can earn credit for this and other courses with ISSUP


ICUDDR
The International Consortium of Universities for Drug Demand Reduction
ICUDDR stands for the International Consortium of Universities for Drug Demand Reduction
✓ Global consortium of universities to promote academic programs that focus on science-based prevention and treatment
✓ Collaborative forum for individuals and organizations to support and share curricula, particularly this Universal Curriculum series, and experiences in the teaching and training of prevention and treatment knowledge
Cont.
U.S. DEPARTMENT of STATE
0.7
MODULE - 0

ICUDDR stands for the International Consortium of Universities for Drug Demand Reduction

Learn about specialized addiction programs at universities worldwide at www.icuddr.com

THE COLOMBO PLAN

Global Centre for Credentialing and Certification

GCCC stands for the Global Centre for Credentialing and Certification of Addiction Professionals

- ✓ The hours that you put into this training can be logged at GCCC and qualify you for exams and professional credentials
- ✓ GCCC credentials will help accelerate your career by indicating your passion and commitment to high standards

Cont.

GCCC stands for the Global Centre for Credentialing and Certification of Addiction Professionals

Learn about how to apply the latest in research-based prevention and treatment at: www.globalccc.org

U.S. DEPARTMENT of STATE 0.10 MODULE - 0

Who funds and supports this global community of substance use professionals?

The U.S. Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL) which is funded by the U.S. taxpayer

Where does this global community of substance use professionals meet?

- ✓ Digitally- through ISSUP and its networks and
- ✓ Face to face – through trainings, on university campus settings, and at conferences held at the global, national regional and local levels

How does this global community of substance use professionals operate?

In the context of a larger international drug control environment that includes:

- United Nation's three international Drug Control Treaties or "Conventions"
- Commission on Narcotic Drugs (CND)
- International Narcotics Control Board (INCB)

What are the key international organizations which operate in the context of this larger drug control environment?

DAP Drug Advisory Programme	The Colombo Plan Drug Advisory Program (DAP)
Inter-American Drug Abuse Control Commission	The Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States (OAS)
AFRICAN UNION	The African Union Commission (AUC)
UNODC United Nations Office on Drugs and Crime	The United Nations Office on Drugs and Crime (UNODC)
World Health Organization	The World Health Organization (WHO)

ISSUP INTERNATIONAL SOCIETY OF SUBSTANCE USE PROFESSIONALS

How can I participate in this global community of substance use professionals?

The easiest way is to become an active member of ISSUP!

- ✓ Register for free on the ISSUP website at www.issup.net
- ✓ Click on the "Apply for Membership" icon
- ✓ Select one of four levels of membership -all are free!
- ✓ Begin networking with others on an ongoing basis

It takes only a few minutes to register and you can immediately connect with over 10,000 ISSUP members worldwide!

What are the benefits of being an active member of this global community of substance use professionals?
You can:

- ✓ Stay informed
- ✓ Implement best practices
- ✓ Access training and mentoring
- ✓ Turn training into credentials
- ✓ Access job postings
- ✓ Access up-to-date research
- ✓ Join a professional network
- ✓ Interact with other professional networks

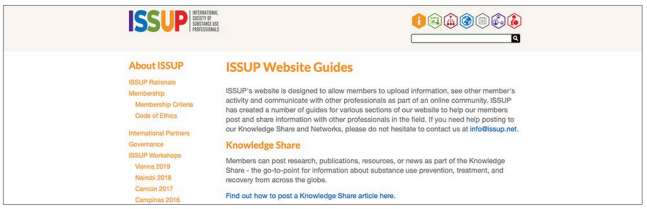
CALL TO ACTION

Next Steps

1. Join ISSUP at www.issup.net
2. Complete this training to earn credit
3. Send your credit hours to GCCC at www.globalccc.org

Participate in ISSUP

- Post on ISSUP: Find easy instructions for how to post on the ISSUP website
- Engage ISSUP's Networks: Connect with colleagues and broaden your impact


ISSUP
About ISSUP
ISSUP Rationale
Membership
Membership Criteria
Code of Ethics
International Partners
Governance
ISSUP Workshops
Vienna 2019
Nairobi 2018
Cancún 2017
Campinas 2016
ISSUP Website Guides
ISSUP's website is designed to allow members to upload information, see other member's activity and communicate with other professionals as part of an online community. ISSUP has created a number of guides for various sections of our website to help our members post and share information with other professionals in the field. If you need help posting to our Knowledge Share and Networks, please do not hesitate to contact us at info@issup.net.
Knowledge Share
Members can post research, publications, resources, or news as part of the Knowledge Share - the go-to-point for information about substance use prevention, treatment, and recovery from across the globe.
Find out how to post a Knowledge Share article here.

U.S. DEPARTMENT of STATE 0.17 MODULE - 0

MODULE 1

TRAINING INTRODUCTION

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Training goals and learning objectives 21
PowerPoint slides 22
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Summary 45

Content and Timeline	
Activity	***Time***
Ceremonial welcome	20 minutes
Trainer welcome, housekeeping and ground rules	10 minutes
Partner exercise: Introductions	50 minutes
Presentation: Training Materials	10 minutes
Break	*15 minutes*
Presentation: Why this training?	15 minutes
Large group exercise: Training expectations	15 minutes
Individual exercise: The Labyrinth	20 minutes
Presentation: Care Pathway	10 minutes

Module 1 Goals and Objectives

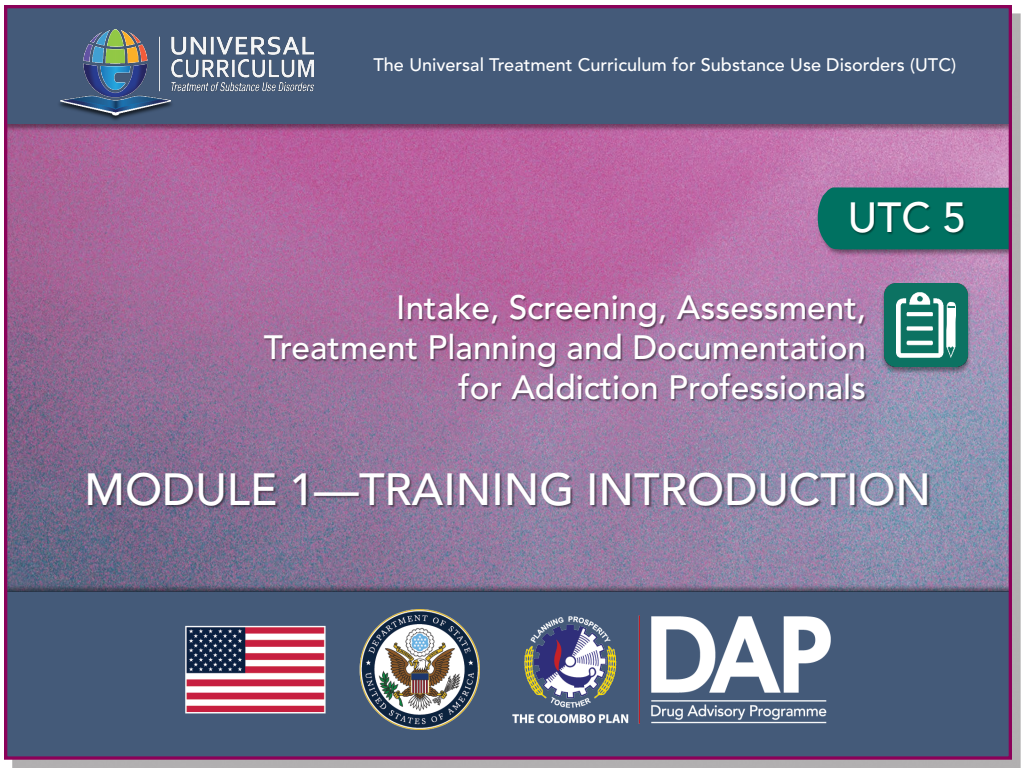
Training goals

- To create a positive learning community and environment;
- To give participants background information about why the training is being done;
- To give participants a summary of the overall training goals, objectives, and learning approach of the course; and,
- To introduce essential forms for documentation.

Learning objectives

Participants who complete Module 1 will be able to:

- Explain the overall training goals and at least four objectives of the 5-day training;
- State at least one personal learning goal; and,
- Identify the essential forms for documentation.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UTC 5
Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals
MODULE 1—TRAINING INTRODUCTION
THE COLOMBO PLAN
DAP
Drug Advisory Programme

Module 1 Learning Objectives

- Explain the overall training goals and at least 4 objectives of the 5-day training
- State at least 1 personal learning goal

1.2

Partner Exercise: Introductions

- What is your name?
- In what town do you live and work?
- What is your job title?
- What does your job entail?
- What do you like about assessment and treatment planning?

1.3

Training Materials

1.4

Break

15 minutes

1.5

The Global Problem

- 269 million people between the ages of 15 and 64 used illicit substances at least once in 2018

Source: UNODC. (2020). World drug report 2020. New York: United Nations.

1.6

The Global Problem

- 35.6 million people suffer from drug use disorders
- People who suffer from drug use disorder need treatment

Source: UNODC (2020). World Drug Report 2020. New York: United Nations

1.7

The Global Problem

- An estimated 11.3 million people injected drugs in 2018
- About 12.6% of those who inject drugs lives with HIV amounting to 1.4 million people
- About 48.5% of PWID, or some 5.5 million people, are living with Hepatitis C

Source: UNODC (2020). World Drug Report 2020. New York: United Nations.

1.8

The Global Problem

- Global consequences of SUDs are far-reaching and include:
  - Higher rates of hepatitis and tuberculosis
  - Lost productivity
  - Injuries and deaths from automobile and other accidents
  - Overdose deaths
  - Suicides
  - Violence

1.9

The Global Problem

- "There continues to be an enormous unmet need for drug use prevention, treatment, care and support, particularly in developing countries."

  Yuri Fedotov, Executive Director, UNODC (2010 to 2019)

Source: UNODC. (2011). *World drug report 2011* (p. 9). New York: United Nations.

1.10

Training Series Goals

- Build international treatment capacity through:
  - Training
  - Professionalizing
  - Expanding the workforce

1.11

Courses in the Series

- UTC 1: *Introduction to the Science of Addiction* (3 days)
  - Foundational, not how-to or skills-based course
  - Overview of the physiology of addiction as a brain disease and the pharmacology of psychoactive substances

1.12

Courses in the Series

- UTC 2: *Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals* (5 days)
  - Builds the foundation for understanding SUD treatment and the continuum of care
  - Provides an overview of recovery and recovery management, stages of change, components of SUD treatment and evidence-based practices

1.13

Courses in the Series

- UTC 3: *Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals* (3 days)
  - Provides an overview of co-occurring disorders (COD), its relationship to one another
  - Discusses COD treatment and related issues as well as mental and medical disorders that commonly co-occur with SUD

1.14

Courses in the Series

- UTC 4: *Basic Counseling Skills for Addiction Professionals* (5 days)
  - Provides the basic understanding of the helping relationship
  - Provides opportunities to enhance core counseling and motivational interviewing skills
  - Introduces psychoeducation and recovery skills building as components of SUD treatment

1.15

Courses in the Series

- UTC 6: *Case Management for Addiction Professionals* (2 days)
  - Provides understanding of case management in SUD treatment
  - Describes case management functions (planning, linkage, monitoring, advocacy, consultation, and collaboration)
  - Provides opportunities to practice case management

1.16

Courses in the Series

- UTC 7: *Crisis Intervention for Addiction Professionals* (2 days)
  - Develops an understanding of crisis
  - Provides guidelines for crisis management, managing suicide risk, and avoiding your own crisis (counselor self-care)

1.17

Courses in the Series

- UTC 8: *Ethics for Addiction Professionals* (4 days)
  - Develops an understanding of ethics in SUD treatment practice
  - Provides an overview of the standards of professional conduct as defined in the Code of Ethics
  - Introduces the ethical decision-making Model and provides opportunities for practice

1.18

UTC 5

- Skills-based course
- Effective, integrated screening, assessment and treatment planning
- Highlights the importance of documentation

1.19

UTC 5 Learning Objectives

- Identify factors affecting client engagement and retention
- Identify promising practices that may be practically implemented in your program
- Describe the process of screening and brief intervention

1.20

UTC 5 Learning Objectives

- Demonstrate ability to screen clients using the ASSIST-BI
- Describe the process of initial assessment
- Describe the process of comprehensive assessment
- Identify instruments for measuring the different life areas/problems

1.21

UTC 5 Learning Objectives

- List the 6 elements of a narrative summary
- Identify the critical aspects of person-centered planning
- List the 5 features for treatment plan objectives
- List the 5 elements for treatment plan interventions
- Describe how structured documentation supports effective treatment
- Demonstrate beginning ability to use the Mapping Technique

1.22

Large-Group Exercise: Training Expectations

- Write 2 expectations on an index card
- Select partner from group
- Trade cards

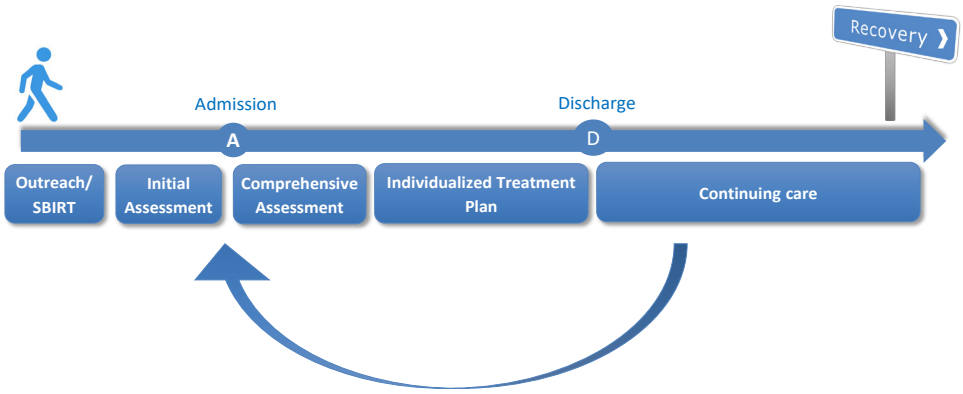
1.23

Individual Exercise: Labyrinth

- Turn to Resource page 1.4
- Using small picture - directions for the activity

1.24

Care Pathway



1.25

Resource Page 1.1: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Criteria for Substance Use Disorder[1]

Substance Use Disorder (SUD) is a problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
8. Recurrent use of the substance in situations in which it is physically hazardous.
9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either:
    a. The characteristic withdrawal syndrome for the substance (excludes Phencyclidine, Other Hallucinogens, and Inhalants).
    b. The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

    Note: This criterion is not considered met for those taking opioids, sedatives, hypnotics or anxiolytics, or stimulant medications solely under appropriate medical supervision.

    Note: DSM-5 states that two or three symptoms indicate a mild substance use disorder; four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder.

[1] https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics

Resource Page 1.2 : ICD-11 Classification of Mental and Behaviour Disorder

Disorders due to substance use include single episodes of harmful substance use, substance use disorders (harmful substance use and substance dependence), and substance-induced disorders such as substance intoxication, substance withdrawal and substance-induced mental disorders, sexual dysfunctions and sleep-wake disorders.

Disorders due to use of substances

Disorders due to use of substance are characterised by the pattern and consequences of substance use. In addition to Substance intoxication, Substance has dependence-inducing properties, resulting in Substance dependence in some people and Substance withdrawal when use is reduced or discontinued. Substance is implicated in a wide range of harms affecting most organs and systems of the body, which may be classified as Single episode of harmful use and Harmful pattern of use. Harm to others resulting from behaviour during Substance intoxication is included in the definitions of Harmful use of substance. Several substance-induced mental disorders and substance-related forms of neurocognitive impairment are recognised.

Single episode of harmful use of substances

A single episode of use of substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following:

(1) behaviour related to intoxication;

(2) direct or secondary toxic effects on body organs and systems; or

(3) a harmful route of administration.

Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behavior due to substance intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies.

This diagnosis should not be made if the harm is attributed to a known pattern of substance use.

Exclusion

- Harmful pattern of use of substance
- Substance Dependence

Harmful pattern of use of substances

A pattern of psychoactive substance use that has caused damage to a person's physical

[1] www.who.int/substance_abuse/terminology/ICD10ClinicalDiagnosis.pdf

or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of psychoactive substance use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous. Harm to health of the individual occurs due to one or more of the following:

(1) behaviour related to intoxication;

(2) direct or secondary toxic effects on body organs and systems; or

(3) a harmful route of administration.

Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to psychoactive substance intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of psychoactive substance applies.

Exclusion

- Substance Dependence
- Episode of Harmful Use of Substance

Substance Dependence

Dependence on a psychoactive substance is a disorder of regulation of psychoactive substance use arising from repeated or continuous use of psychoactive substance. The characteristic feature is:

- a strong internal drive to use the psychoactive substance, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use the psychoactive substance.
- physiological features of dependence may also be present, including tolerance to the effects of the psychoactive substance, withdrawal symptoms following cessation or reduction in use of the psychoactive substance, or repeated use of psychoactive substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms.

The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if psychoactive substance use is continuous (daily or almost daily) for at least 1 month.

Exclusion

- Episode of Harmful Use of Substance
- Harmful pattern of use of substance

Intoxication

Intoxication is a clinically significant transient condition that develops during or shortly after the consumption of a psychoactive substance that is characterized by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of psychoactive substance and their intensity is closely related to the amount consumed. Presenting features may include impaired attention, inappropriate or aggressive behaviour, lability of mood, impaired judgment, poor coordination, unsteady gait, and slurred speech. At more severe levels of intoxication, stupor or coma may occur.

Withdrawal

Withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of alcohol in individuals who have developed dependence or have used psycyhoactive substances for a prolonged period or in large amounts. Presenting features of withdrawal may include autonomic hyperactivity, increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psychomotor agitation, transient visual, tactile or auditory hallucinations, and distractibility. Less commonly, the withdrawal state is complicated by seizures. The withdrawal state may progress to a very severe form of delirium characterized by confusion and disorientation, delusions, and prolonged visual, tactile or auditory hallucinations.

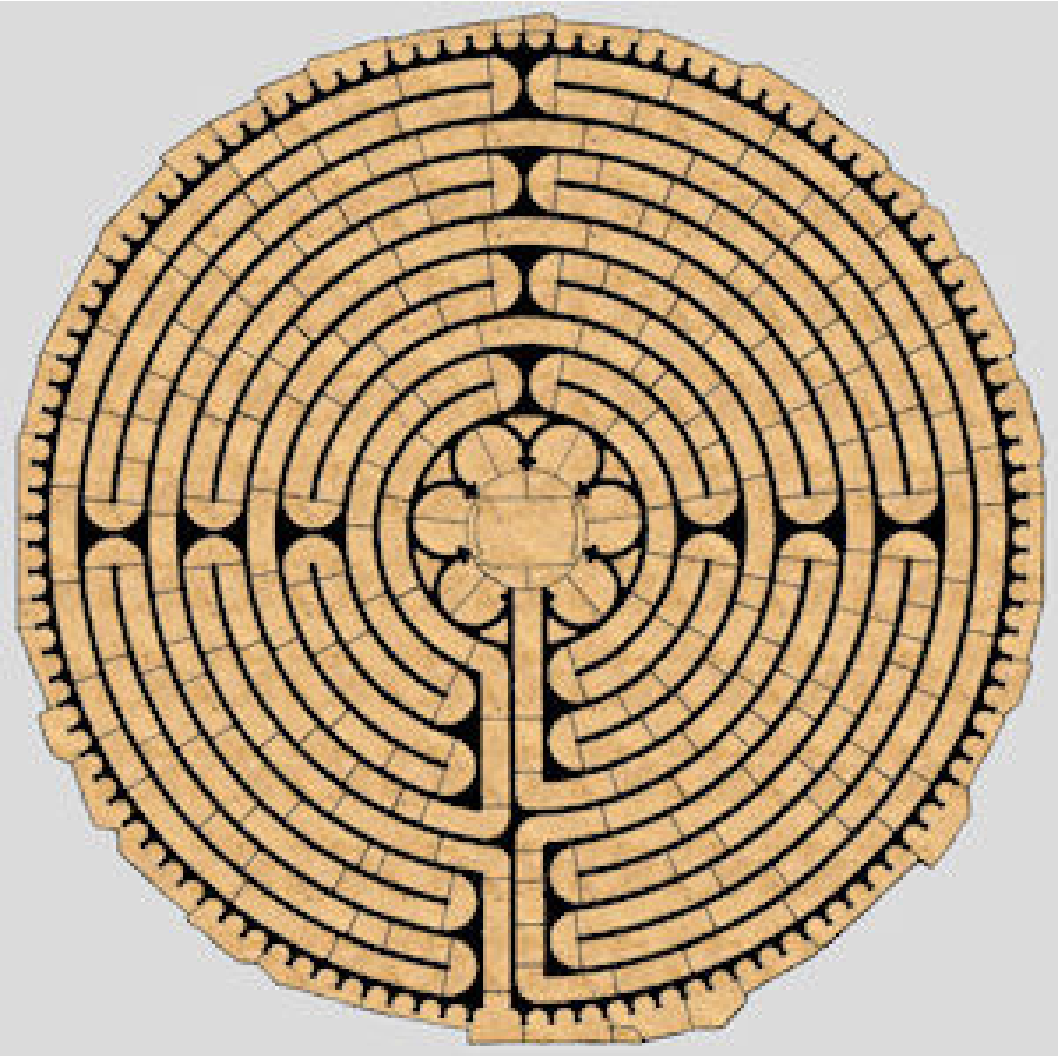
Note: The detailed diagnostic criteria can be accessed at the WHO website.

Note: At the time of the updating of this Course, the ICD-11 was in the final stages of revision and not yet formally released. However, INL and the Treatment Expert Advisory Group, in the interest of providing UC trainees with the latest and most current guidance on substance use disorders, requested inclusion of the ICD-11 language, 'as is.'

Resource Page 1.3: The Universal Treatment Curriculum for Substance Use Disorders (UTC) Basic Level Training Series

UTC 1:	*Introduction to the Science of Addiction*
UTC 2:	*Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals*
UTC 3:	*Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals*
UTC 4:	*Basic Counseling Skills for Addiction Professionals*
UTC 5:	*Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals* **(this course)**
UTC 6:	*Case Management for Addiction Professionals*
UTC 7:	*Crisis Intervention for Addiction Professionals*
UTC 8:	*Ethics for Addiction Professionals*

Resource Page 1.4 Chartres Labyrinth Reproduction



Module 1—Training Introduction, Summary

The global problem

- Psychoactive substance use continues to be a global problem. A survey done by the United Nations Office on Drugs and Crime (or UNODC) found that, in 2018, 269 million people between ages 15 and 64 used illicit substances at least once in 20181.
- Illicit substances in the survey included opioids, cannabis, cocaine, other amphetamine-type stimulants, hallucinogens, and ecstasy, among others.
- A significant number of people who use psychoactive substances develop SUDs.
- The UNODC report estimates a total of 35.6 million people between ages 15 and 64 suffer from drug use disorders. People who suffer from drug use disorders or people with drug use disorders are those subset of people who use drugs and are in need of treatment, health and social care, and rehabilitation.
- Substance use disorder is a general term used to describe a range of problems associated with substance use (including illicit drugs and misuse of prescribed medications).
- There are two classification systems used in the diagnosis of drug use disorders or SUDs, the Diagnostic Statistical Manual (DSM) and the International Classification of Diseases (ICD).
- Diagnostic Statistical Manual (DSM), published by the American Psychiatric Association, offers a common language and standards criteria for the classification of mental disorders.
- In 2013, the APA updated the DSM, replacing the categories of substance abuse and substance dependence with a single category: substance use disorder (SUD).
- SUD is defined as a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the 11 criteria occurring in a 12-month period. The level of severity is measured on a continuum from mild to severe.
- The symptoms associated with SUD fall into four major groupings: impaired control; social impairment; risky use; and pharmacological criteria (i.e., tolerance and withdrawal).
- Another classification system is the International Classification of Diseases (ICD), published by the World Health Organization.
- It is distinguished from the DSM in that it covers health as a whole. Under ICD-11, patterns of psychoactive substance use are labelled,
    - Single episode of harmful use of a psychoactive substance - refers to a single episode of use of psychoactive substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others.

- Harmful use - if the pattern is causing damage to health. The damage may be physical (as in the case of hepatitis from self-administration of injected drugs) or mental (e.g., episodes of depressive disorder secondary to heavy consumption of alcohol), and
- Dependence - if the use of a substance or a class of substances takes on a much more higher priority for a given individual than other behaviors that once had greater value. There is compulsion to use drugs and physical signs of a withdrawal state upon abstinence.
- Intoxication – a clinically significant transient condition that develops during or shortly after the consumption characterised by disturbances in consciousness, cognition, perception, affect behaviour or coordination.
- Withdrawal – is a clinically significant cluster of symptoms, behaviors and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of alcohol in individuals who have developed dependence or have used psychoactive substances for a prolonged period or in large amounts. Presenting features of withdrawal may include autonomic hyperactivity, increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psycho-motor agitation, transient visual, tactile or auditory hallucinations, and distractibility.

- The UNODC report estimates a total of 35.6 million people between ages 15 and 64 suffer from drug use disorders. People who suffer from drug use disorders or people with drug use disorders are those subset of people who use drugs and are in need of treatment, health and social care, and rehabilitation.
- The U.N Survey also found that:
  - 11.3 million people injected drugs in 2018
  - About 12.6 percent (1.4 million) of those who inject drugs are HIV positive.
  - About 48.5 percent (5.5 million) of those who inject drugs are infected with Hepatitis C.
- Global consequences of SUDs are far-reaching and include, for example:
  - Higher rates of HIV/AIDS, hepatitis and tuberculosis;
  - Lost productivity;
  - Injuries and death due to automobile and other accidents;
  - Overdose hospitalizations and deaths;
  - Suicides; and
  - Violence.
- The numbers are significant. Yuri Fedotov, Executive Director of UNODC (2010 to 2019), notes that "there continues to be an enormous unmet need for drug use prevention, treatment, care and support, particularly in developing countries." There are a number of reasons for this, but one reason is a lack of adequate treatment capacity.

The training series

- This course is part of a training series developed through funding from the U.S. Department of State to The Colombo Plan.
- The overall goal of the training series is to reduce the health, social, and economic problems associated with SUDs by building international treatment capacity through training, professionalizing, and expanding the global treatment workforce.

The series prepares counselors for professional certification at the entry level by providing them with necessary information and with specific skills training. See You will find a list of the courses included in the training series on Resource Page 1.3 in your

Other Courses in the series

- UTC 1: Introduction to the Science of Addiction is a 3-day course that presents a comprehensive overview of addiction, provides an understanding of the physiology of addiction as a brain disease, and describes the pharmacology of psychoactive substances.
- UTC 2: Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals is a 5-day foundational course. By this we mean that it provides a necessary foundation for learning about SUD treatment. It is not a how-to or skills-based course, but it provides a context for the skills-based courses later in the series. UTC 2 provides an overview of recovery, recovery management, stages of change, principles of effective treatment, components of treatment, factors affecting treatment outcomes, and evidence-based practices, including couples and family counseling.
- UTC 3: Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals is a 3-day course. It is also a foundational course and provides an overview of the relationship of co-occurring disorders to one another and to SUD related treatment issues. It outlines brief descriptions of the most commonly cooccurring mental and medical disorders with SUD.
- UTC 4: Basic Counseling Skills for Addiction Professionals is a 5-day skills-based course. It provides an overview of the helping relationship. It also provides opportunities to learn and practice core counseling and basic motivational interviewing skills which are essential at every stage of treatment and in every type of counseling situation, including working with families. Basic group (for clients and family members) counseling and psychoeducational group skills also are covered in the course.
- UTC 5: Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals is a 5-day skills-based course that teaches effective, integrated assessment and treatment/service planning. It also addresses the importance of documentation in the treatment process.

[1] United Nations Office on Drugs and Crime, World Drug Report 2020
[2] UNODC. (2011). World drug report 2011 (p.9). New York: United Nations.

- UTC 6: Case Management for Addiction Professionals is a 2-day foundational and skills-based course that provides an overview of case management in SUD treatment and provides skills practice in case management functions such as planning, linkage, monitoring, advocacy, consultation, and collaboration.
- UTC 7: Crisis Intervention for Addiction Professionals, a 2-day course, addresses the concept of crisis as a part of life and provides guidelines for and practice in crisis management, including managing suicide risk. It also addresses ways counselors can avoid personal crisis situations by providing information and exercises about counselor self-care.
- UTC 8: Ethics for Addiction Professionals is a 4-day course that aims to develop an understanding of ethics in SUD treatment and provides an overview of professional conduct as defined in the Code of Ethics. It provides the opportunity to learn and practice the process of ethical decision making. The course also addresses the importance of supervision as part of ethical practice.

MODULE 2

WELCOMING ENVIRONMENT, TREATMENT ENGAGEMENT AND RETENTION

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Summary 63

Content and Timeline	
Activity	***Time***
Introduction to Module 2	5 minutes
Large group exercise: Guided reflection on how services are experienced at participants' programs	25 minutes
Presentation: Client Engagement and Retention	45 minutes
Lunch	*60 minutes*
Checklist and reflective exercise: Observation and promising practices for participants to explore with program colleagues	20 minutes

Module 2 Goals and Objectives

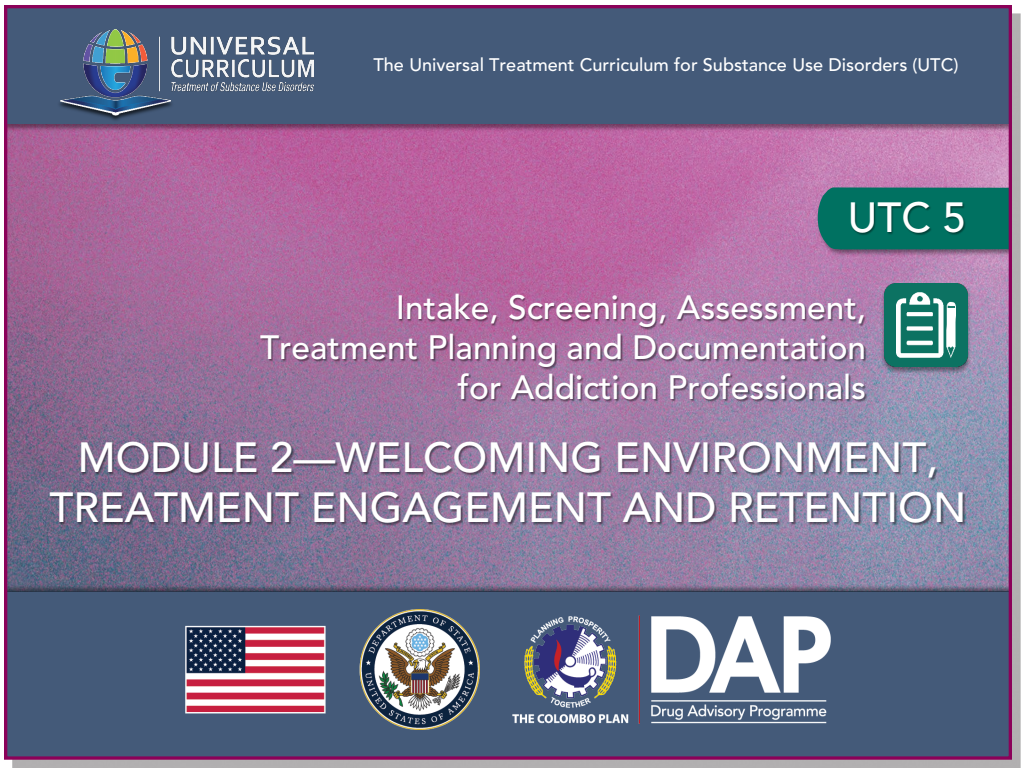
Training goals

- To provide information on approaches that will make treatment environments more welcoming, positive, and supportive;
- To provide participants with an opportunity to reflect on what the client may experience as they enter treatment; and,
- To provide participants with an opportunity to review and identify promising practices to help their programs become more welcoming, improve engagement with clients, and increase retention rates.

Learning objectives

Participants who complete Module 2 will be able to:

- List at least four strategies that contribute to a welcoming environment for clients as they enter treatment;
- Understand and explain how clients currently experience participants' treatment environments; and,
- Identify promising practices that can be practically implemented in participants' programs.


UNIVERSAL CURRICULUM
Treatment of Substance Use Disorders
The Universal Treatment Curriculum for Substance Use Disorders (UTC)
UTC 5
Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals
MODULE 2—WELCOMING ENVIRONMENT, TREATMENT ENGAGEMENT AND RETENTION
THE COLOMBO PLAN
DAP
Drug Advisory Programme

Module 2 Learning Objectives

- Understand and explain how clients currently experience your treatment environment
- Identify factors affecting client engagement and retention
- Identify promising practices that may be practically implemented in your program

2.2

Exercise: Guided Reflection—What's It Like To Enter Treatment?

- To make your treatment environment more welcoming, you must first be able to feel what it is like to be the client: You must walk in their shoes

2.3

Group Discussion

- What was your experience like?
- What felt good to you as a client, and what felt not so good?
- What changes would you like to see in how your program welcomes new clients?

2.4

Factors to Increase Client Engagement and Retention

- Accessible treatment
- Reduce waiting time for treatment
- A friendly and welcoming environment
- Culturally sensitive environment
- Focus on a client's immediate needs; tailor treatment to a client's individual circumstances and needs
- Delivery of information and guidance
- Establish clear two-way expectations early on
- Establish a therapeutic alliance built on trust
- Develop motivational strategies that focus on the individual patient

2.5

Factors to Increase Client Engagement and Retention

Design treatment to boost retention by addressing cognitive issues and personality disorders

Provide training to help clinical staff establish and maintain a strong therapeutic alliance.

3 components contribute to a strong therapeutic alliance:

- 1. Agreement on goals
- 2. Agreement on interventions
- 3. Effective bond between patient and therapist
- When the patient does not perceive these components, then the alliance is low.

Brorson HH, et al. Drop-out from addiction treatment: a systematic review of risk factors. Clin Psychol Rev. 2013 Dec;33(8):1010-24
McKellar, J.et al., Pretreatment and during treatment risk factors for dropout among patients with substance use disorders Addictive Behaviors, 31 (3) (2006), pp. 450-460

2.6

Accessibility

A service is accessible when:

- It is available to all potential people at a time and place suitable to meet their ***assessed needs and delivered in a user-friendly way***.
- When it is designed to meet the needs and aspirations of the individual, that is, with enough flexibility to offer a ***service that is as person-centered*** as possible.

Source: Effective Interventions Unit. (2000). Integrated Care for Drug Users. Principles and practice (p. 31). Edinburgh.

2.7

Addressing Barriers to Treatment

To address barriers to treatment, consider:

- ***Characteristics of the service***: range of treatment services available, location and territorial distribution, hours of operation, attitudes of the personnel (administrative and clinical), admission procedures, waiting times, and others
- ***Individual characteristics of the person:*** including gender, age group, ethnicity, rurality, habitability, and others

2.8

SUD Treatment Respects the Dignity of the Individual

- Treatment that honors the dignity of the individual patient is treatment which, as a matter of law, values, recognizes, and respects an individual regardless of his/her condition or situation
- The entry process should include a series of practices, attitudes and behaviors on the part of all team members, that are caring and in line with the recognition of dignity

Funk M, Drew N, Baudel M. Dignity in mental health. Occoquan, VA: World Federation for Mental Health; 2015. Supporting dignity through mental health legislation; pp. 14–5

2.9

Understand and Involve the Person Served

- Promoting patients' engagement can be difficult for treatment programs
- Taking the time to engage patients, know their reactions and opinions about improvement needs, and prepare them for anticipated changes in the program's design and operation, are ways to better meet the particular needs of each person.
- Likewise, active participation in their own therapeutic process is essential.

Network for the Improvement of Addiction Treatment (NIATx), University of Wisconsin-Madison, USA. 2.10

Lunch

60 minutes

2.11

Reflective Exercise

- Review Resource page 2.1
- Circle the practices that are being implemented
- Reflect on the changes that you would like to implement.

2.12

Resource Page 2.1: Other Promising Practices—Increasing Treatment Initiation, Engagement, and Retention

1. Beef up support in the first 72 hours of treatment through closer observation, increased general interaction.
2. Introduce new group members to senior peers; assign a peer buddy/mentor in residential services.
3. Develop realistic and individualized treatment plans and goals that reflect the client's needs and that are flexible enough to adapt to his or her progress.
4. Give objective feedback about the problems and processes of change in order to foster credibility and trustworthiness.
5. Ensure each client has an opportunity early on to tell his or her story and voice his or her needs and not just to fill out forms or answer questions.
6. Avoid repetition in paperwork.
7. Start and end sessions on time.
8. Be responsive to requests for information and encourage support staff to do the same.
9. Send a brief handwritten note or card after a client's first session.
10. Write down appointment times for the client.
11. Offer reminders for appointments.
12. Call or write a client after missed sessions.
13. Re-schedule missed appointments immediately.
14. Identify barriers to a client's continuing in treatment. Address these barriers directly, if possible (e.g., providing child care or transportation) or help clients problem-solve.
15. Track when clients are most likely to leave treatment (after first or second session; weekends; during transfers; etc.) and apply interventions (e.g., call clients immediately if they miss a session).
16. The professional believes that the person is capable of changing.
17. Develop rapport with family members.
18. Measure client satisfaction. Consult about their experience in the program
19. Reward consistent attendance (recognition, certificates, small gifts).
20. Contact clients who have left treatment and ask them what might have helped them stay longer.

Resource Page 2.2. Barriers to Access

Tanahashi's model is useful for analyzing equity in access to health care. It allows identifying stages in the process of access to health that can represent "bottlenecks"; facilitates the identification of specific groups with unmet needs; and identifies barriers and facilitators to achieve effective coverage in each of these groups.

Barriers are understood as those factors that impede the target population of a health or social security service from fully using it, and which reduce effective coverage of a health program or service.

Tanahashi's model considers four stages in the access process to obtain effective coverage:

1. Availability of services: refers to the available supply of services, considers the relationship between the volume and type of existing services and the volume of the target population that requires treatment. At this stage, the availability of care spaces, treatment centers, human resources, infrastructure and required equipment, medicines and other supplies that allow the provision of health care can be considered.

2. Accessibility of service: refers to the way in which services are accessible to the population that requires them. Three relevant dimensions are considered:

    - Physics, such as distance, connectivity, and existence and transport time. It should be considered that the ""value of time"" will be different for different social groups, depending on their level of autonomy, responsibility with third parties, employment conditions, family and social aspects, among other factors.

    - The administrative-organizational, is related to the requirements and administrative procedures that the person must comply with to access care and that may hinder their admission. It considers aspects such as: the procedures for obtaining hours, the established service hours.

    - Financial, refers to the economic costs associated with access to treatment services, which can discourage people from using them. Consider the cost of transportation, cost of treatment, medications, out-of-pocket expenses, and lost earnings from work.

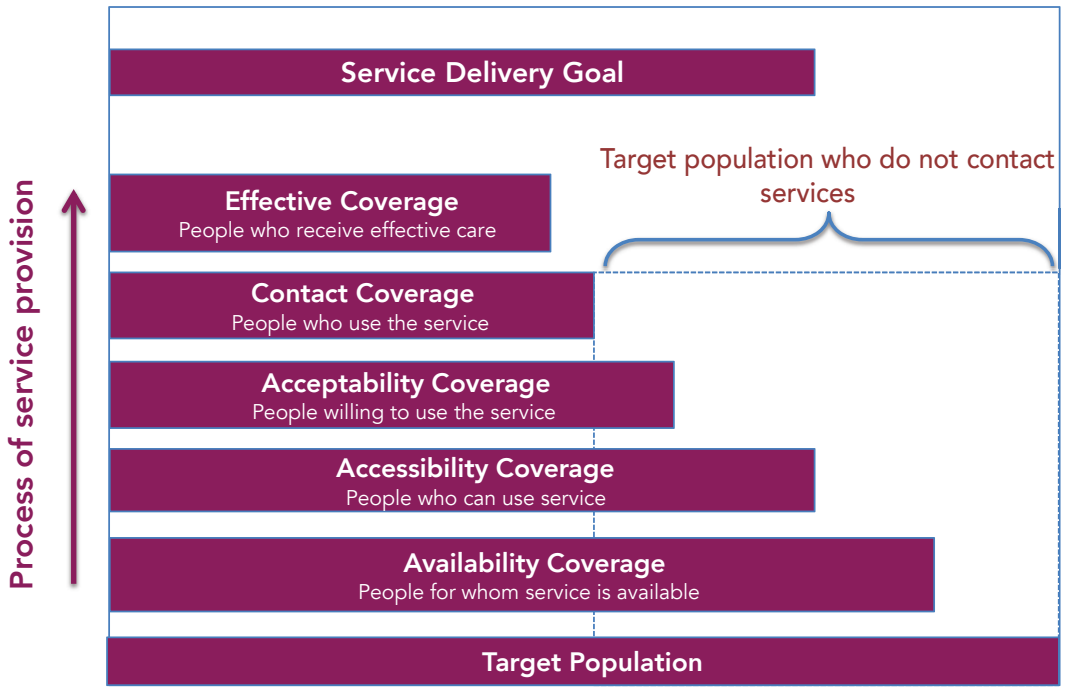
3. Acceptability of services: The degree to which the population or specific social groups accept the services, increasing or decreasing the probability that they will make use of them. This is related to the perception that people have of the benefits and the care model offered to them and is influenced by individual variables, by social, cultural, and religious factors, such as beliefs, norms and values, among others

4. Contact with the service: It is the fourth and last stage of the process of access to health and refers to the use of services, which is related to the proportion of the population that makes contact with them to receive care. Research shows that the probability of a second contact will largely be defined from the first contact, thus influencing adherence to programs or their abandonment.

Finally, the model raises the effective coverage of the service, understood as the proportion of the population that receives effective care, where the performance of the service delivered is seen as satisfactory to the extent that it achieves a specific result. In this sense, the proportion of people who fully complete the recommendation for treatment or program can be considered, which is directly related to adherence.

From this perspective, access, abandonment or adherence to health services can be explained by identifiable facilitating elements and obstacles in the different phases of the model, where there are social groups - generally the most vulnerable populations - that face various barriers and have no contact with the services.

The Tanahashi model of evaluating health service coverage



Campbell (2012). Adapted from Tanahashi T. Health service coverage and its evaluation. Bull World Health Organ. 1978;56(2):295–303

Source: Tanahashi T. Health service coverage and its evaluation. Bull World Health Organ. 1978;56(2):295–303. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2395571/

Hirmas, M., Poffald, L., Jasmen, A., Aguilera, X., Delgado, I., & Vega, J. (2013). Barreras y facilitadores de acceso a la atención de salud: una revisión sistemática cualitativa. Revista Panamericana De Salud Pública, 33, 15.

Module 2- Welcoming Environment, Treatment Engagement and Retention, Summary

Factors to increase client engagement and retention includes -

1. Accessible treatment: reduce waiting time for treatment, same day admission or short waiting lists, seek to respond quickly to treatment requests to maximize patient engagement with treatment. Offer an initial appointment as soon as possible, preferably the same day a client calls.

2. Reduce waiting time for treatment: a person's motivation for change can vary. Today this person may be motivated to enter treatment, and not tomorrow. The lives of people with problematic substance use often involve multiple risk situations that require that once the person makes contact with the health system or the treatment device, it is available to provide care.

3. Create a "welcoming" environment: there are a number of ways to make a person welcome in treatment. Some to consider are: provide a pleasant, homelike, and private waiting area; make sure the first person a client meets offers a pleasant and warm greeting; make sure your waiting area, group rooms, and bathrooms are attractive and clean; make sure posters and notices on the wall or bulletin board are up-to date and provide positive and uplifting messages not punitive and fear-inducing messages; Provide coffee or other refreshments; provide appropriate reading materials for waiting clients; greet clients personally at each visit; and, Treat a client as a "valued customer" (e.g., "We're glad you chose our services"); thank people for coming; and express interest in their recovery.

4. Creating a culturally sensitive environment: the development of culturally sensitive environment is vital to the effectiveness of behavioral health services. "Culturally responsiveorganizationalstrategiesandclinicalservicescanhelpmitigateorganizational risk and provide cost-effective treatment, in part by matching services to client needs more appropriately from the outset" (SAMHSA, 2014). SAMHSA developed a special TIP (Treatment Improve Protocol) Improving Cultural Competence, TIP 59. A culturally sensitive environment pays attention to "culture" as a broad concept that refers to a shared set of beliefs, norms, and values among any group of people, whether based on ethnicity or on a shared affiliation and identity.

5. Focus on the client's immediate concerns, rather than the program's; respond to immediate needs; reduce the number and amount of bureaucratic procedures to enter treatment; adapt treatment to the individual circumstances and needs of a client and adjust schedules and activities to respond to the needs and availability of the client.

6. Delivery of information and guidance: provide information on the program philosophy, expectations, treatment and recovery approach, as well as outcomes, and concerns that clients may have at the beginning of treatment; deliver information and guidance by the administrative team regarding services available within the treatment center and in the local community treatment network; address logistics issues (for example, anticipating or solving logistics problems related to the start and duration in treatment,

means of transport to reach the treatment center, number of initial appointments required, etc.); facilitate means of transport to social support services; offer vouchers or certificates of assistance for work, school, etc.; consider and address childcare needs for parents to fully engage in treatment activities.

7. Establish clear two-way expectations early on (e.g., what the client can expect from the program; what the program will expect of the client).

There are practical actions that a program can take to boost retention.

- Identify partners in your community that can help support assessing cognitive functioning and screening for antisocial personality disorder or other personality disorders. If these issues can be found early, then plans to modify treatment to best respond to these issues can be developed and implemented.
- For example, patients who are less than 26 years of age or who have cognitive deficits are less likely to drop-out when they perceive the treatment environment as high in support and low in control. This means that both staff and therapists should not try to control patients, but rather try to involve them in decisions about their treatment.
- Other adjustments that can be developed for patients struggling with cognitive deficits include offering shorter therapy sessions (like 30 minutes) for those who struggle with maintaining focus. Also consider the use of illustrative drawings rather than only words for those with lower abstract reasoning.
- As a reminder there are important components that contribute to a strong therapeutic alliance:
    1. Agreement on goals (Collaborative Goal Setting)
    2. Agreement on interventions (Shared Decision Making)
    3. Effective bond between patient and therapist (The Therapeutic Relationship.
- When these factors are not perceived by the patient then the alliance is low.

Accessibility

- A service is accessible when it is available to all potential people at a time and place suitable to meet their assessed needs and delivered in a user-friendly way and also when it is designed to meet the needs and aspirations of the individual, that is, with enough flexibility to offer a service that is as person-centered as possible.
- In order to enhance treatment accessibility, barriers that interfere with treatment admission and retention must be addressed and understood. These include both aspects of the treatment and aspects of the person being served.

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[3]Brorson HH, et al. Drop-out from addiction treatment: a systematic review of risk factors. Clin Psychol Rev. 2013 Dec;33(8):1010-24

[4]McKellar, J.et al., Pretreatment and during treatment risk factors for dropout among patients with substance use disorders Addictive Behaviors, 31 (3) (2006), pp. 450-460

- To address barriers to treatment, consider:
  - Characteristics of the service, range of treatment services available, location and territorial distribution, hours of operation, attitudes of the personnel (administrative and clinical), admission procedures, waiting times, and others
  - Individual characteristics of the person, including gender, age group, ethnicity, rurality, habitability, and others
  - Characteristics of the individual program, as well as of the individual seeking treatment, can both influence the extent to which patients reach out to a program, follow-up with the program, adhere to treatment recommendations, and receive perceived treatment benefits; some patients are retained and engaged after first contact with a program, while others may abandon the process before obtaining expected health benefits.
  - "Dignified SUD Treatment" involves valuing the person as a subject of law, each person's dignity must be recognized and respected regardless of his/her condition or situation. We can understand dignity as 'the inherent and inalienable worth of all human beings irrespective of social status such as race, gender, physical or mental state'
  - The entry process should include a series of practices, attitudes and behaviors on the part of all team members, that are caring and in line with the recognition of dignity. Some of these considerations may be greeting cordially, looking into the eyes, attending on time, among others.
  - Promoting the person's engagement can be difficult for treatment programs, considering the need to respond to a high demand for care, with budget constraints and high staff turnover.
  - However, taking the time to engage clients, know their reactions and opinion about improvement needs and prepare for anticipated changes in the program's design and operation, are ways in which it is possible to better meet the needs of each person.
  - Likewise, active participation in their own therapeutic process is essential.

[6]Funk M, Drew N, Baudel M. Dignity in mental health. Occoquan, VA: World Federation for Mental Health; 2015. Supporting dignity through mental health legislation; pp. 14–5
[7]Network for the Improvement of Addiction Treatment (NIATx), University of Wisconsin-Madison, USA.

MODULE 3

INTAKE, SCREENING AND BRIEF INTERVENTION

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Training goals and learning objectives 69
PowerPoint slides 71
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Summary 157

Module 3 Goals and Objectives

Training goals

- To provide an overview of the process of screening and brief intervention;
- To familiarize participants with the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST); and,
- To demonstrate the potential effectiveness of ASSIST-linked brief interventions.

Learning objectives

Participants who complete Module 3 will be able to:

- Describe the nature and process of screening;
- Describe the rationale for Screening and Brief Intervention;
- Effectively score and interpret the results of the ASSIST; and
- Utilize the results of the ASSIST in conducting a brief intervention.

Content and Timeline	
Activity	***Time***
Introduction to Module 3	5 minutes
Interactive presentation: Outreach/SBIRT	15 minutes
Interactive presentation: Screening process	20 minutes
Interactive presentation: ASSIST - Administering and coding the ASSIST	60 minutes
Break	*15 minutes*
Interactive presentation and demonstration: Administering and coding the ASSIST	40 minutes
Day 1 Wrap up	5 minutes
End of day 1	
Review of Day 1	10 minutes
Partner exercise: ASSIST role-plays	30 minutes
Interactive presentation: ASSIST-linked brief interventions	50 minutes
Break	*15 minutes*
Small group exercise: ASSIST-linked brief intervention	30 minutes
Reflective exercise: Effective use of the ASSIST in brief interventions	15 minutes

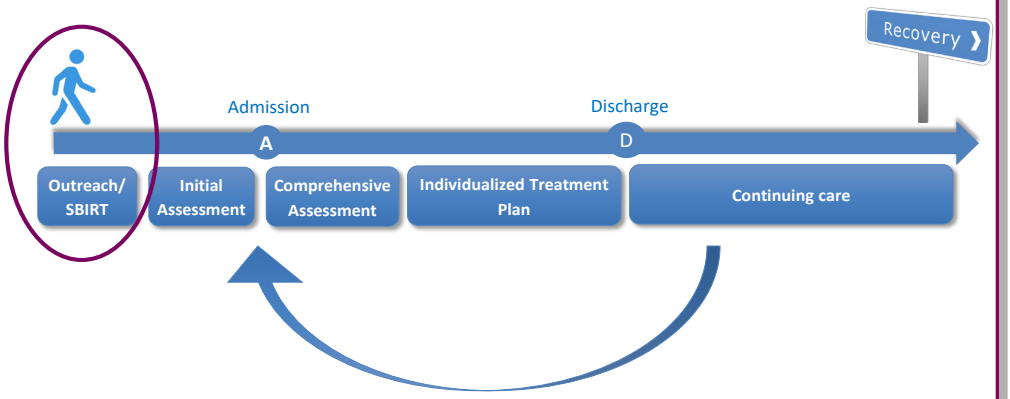
UNIVERSAL CURRICULUM
Treatment of Substance Use Disorders
The Universal Treatment Curriculum for Substance Use Disorders (UTC)
UTC 5
Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals
MODULE 3—SCREENING AND BRIEF INTERVENTION
THE COLOMBO PLAN
DAP
Drug Advisory Programme

Module 3 Learning Objectives

- Describe the nature and process of screening
- Describe the rationale for Screening and Brief Intervention
- Effectively score and interpret the results of the ASSIST
- Utilize the results of the ASSIST in conducting a brief intervention

3.2

Care Pathway



3.3

Outreach / SBIRT

Strategies associated with early and timely contact and screening of people with substance use disorder.

Among them:

- Outreach
- Information Provision
- Screening
- Brief Intervention

3.4

Outreach

The onset of a substance use disorder and the time the individual seeks treatment may be years apart

It is during that period that outreach activities pro-actively seek to establish contact with and motivate individuals who use substances to engage with health care professionals

3.5

Why Outreach?

- Because many people who use substances see treatment programs as:
  - Intimidating
  - Difficult to get to
  - Too rigid or judgmental in their approach
  - Focused only on never using substances again
  - Irrelevant to an individual's immediate needs
  - Too costly

3.6

Outreach

The aim is to minimize the time between the onset of the disorder and the initiation of treatment, thereby reducing the negative health and social effects of drug use

Source:
International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing. World Health Organization and United Nations Office on Drugs

3.7

Screening

Brief procedure used to determine the probability of the presence of a problem, substantiate that there is a reason for concern, or identify the need for further evaluation

Source: SAMHSA (1999) Treatment Improvement Protocol (TIP) Series N. 31 Center for Substance Abuse Treatment. Rockville MD retrieved on 11 July 2014 www.ncbi.nim.nih.gov/books/NBK64369

3.8

Screening

- Determines the presence or absence of a problem
- Not a clinical diagnosis; neither does it enable one to make a clinical diagnosis

Source: Center for Substance Abuse Treatment. (1994). Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Other Infectious Diseases. Treatment Improvement Protocol(TIP) Series 11.

3.9

Screening

- Screening results will determine if:
  - The individual is likely to benefit from a referral for a comprehensive assessment
  - More assessment is warranted or not at this time, or
  - The screening will be repeated at a later time

Source: NCETA as cited Treatnet. (2008). Screening, assessment and treatment planning. http://www.unodc.org/ddt-training/treatment/a.html

3.10

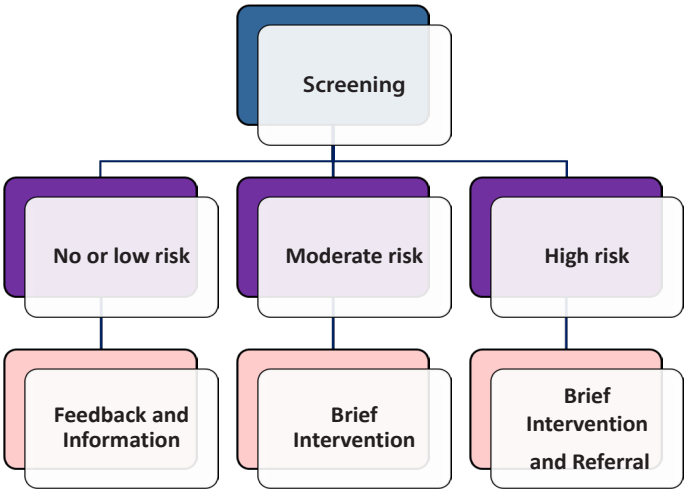
Screening

- Provides an opportunity for education, and/or early intervention
- Alerts provider to risk for interactions
- Offers the opportunity to strengthen the commitment of the person
- Beneficial in reducing high-risk activities for people who do not have a substance use disorder

Source: NCETA as cited Treatnet. (2008). Screening, assessment and treatment planning. http://www.unodc.org/ddt-training/treatment/a.html

3.11

Screening Results



3.12

Tips for Screening

To optimize the accuracy and reliability of information, one must:

- Use a non-judgmental, non-confrontational and respectful approach
- NOT use stigmatizing language
- Include screening questions in the larger assessment of health practices

Source: Treatnet. (2008). *Screening, assessment and treatment planning.* http://www.unodc.org/ddt-training/treatment/a.html

3.13

Validity of Screening Instruments

- Validity is the degree to which a screening tool actually measures what it claims to measure
- Internationally validated screening instruments:
  - AUDIT
  - ASSIST

Source: Treatnet. (2008). *Screening, assessment and treatment planning.* http://www.unodc.org/ddt-training/treatment/a.html

3.14

Detecting Risk Factors Early

Screening can be a significant step to effective treatment:

- The counselor is often the first point of contact
- Early identification and intervention lead to better outcomes
- Clients are often referred to SUD counselors by healthcare workers

Source: Treatnet. (2008). *Screening, assessment and treatment planning.* http://www.unodc.org/ddt-training/treatment/a.html

3.15

What is the ASSIST?

- A self-report measure developed by the World Health Organization (WHO)
- A brief screening questionnaire developed for primary care (first point of contact)
- Covers 8 questions/sections on alcohol, tobacco, and other substances (including injection substance use)
- Elicits information on hazardous, harmful, or dependent use
- Conducted by interview only
- Studied cross-culturally in 8 countries

Source: World Health Organization. (2010). ASSIST-The Alcohol, Smoking and Substance Involvement Screening Test. Geneva: WHO Press.

3.16

Information Generated by the ASSIST

In general, ASSIST provides information about:

- Lifetime substance use
- Previous 3 months substance use
- Problems related to substance use
- Risk of current or future harm
- Dependence
- Injecting

Source: Treatnet. (2008). *Screening, assessment and treatment planning.* http://www.unodc.org/ddt-training/treatment/a.html

3.17

Components

- Patient Support Sheet
- ASSIST Screening Test Form
- Patient Feedback Sheet

3.18

Patient Support Sheet

- List of common (local) names of different psychoactive substances
- Answer Options

3.19

Response Card #1 (Substance list)

Response Card - substances

a. Tobacco products (cigarettes, naswar, nass, chewing tobacco, cigars, etc.)
b. Opioids (opium, heroin, morphine, methadone, codeine, etc.)
c. Cannabis (marijuana, ganja, hashish, etc.)
d. Amphetamine-type stimulants (diet pills, ecstasy, Khat, etc.)
e. Inhalants (glue, petrol, paint thinner, etc.)
f. Sedatives or sleeping pills (Valium, nimetazepam, diazepam, lorezepam, etc.)
g. Hallucinogens (LSD, acid, mushrooms, PCP, ketamine, etc.)
h. Cocaine (coke, crack, etc.)
i. Alcoholic beverages (beer, wine, spirits, etc.)
j. Other – specify:

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.20

Response Card #2 (Frequency of Use)

Given to the client and used for questions 2–5

Never: not used in the last 3 months.

Once or twice: 1 or 2 times in the last 3 months.

Monthly: 1 to 3 times in one month.

Weekly: 1 to 4 times per week.

Daily or almost daily: 5 to 7 times per week.

3.21

Response Card #3 (Frequency of Use)

Given to the client and used for questions 6–8

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

3.22

ASSIST Test Form

1. Use (throughout life)

Recent (last three months)

2. Use
3. Strong desire to consume
4. Problems (health, social, legal, economic) caused by the substance
5. Neglect responsibilities

Ever

6. Third party concern
7. Attempts to reduce or stop use
8. Intravenous use

Source: PAHO-WHO. (2013) "ASSIST Screening Test Components" (slide 25) .

3.23

Question 1: Lifetime Use

- In your life, which of the following substances have you ever tried? (non-medical use only)
  - No
  - Yes
- Ask for all substances
- Record any use (even if only tried once)
- Probe: Not even at a party?
- If "No" to all substances, end the interview.

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.24

Question 2: Recent Use

During the <u>past 3 months</u>, how often have you used the substances you mentioned *(first substance, second substance, etc.)?*

- Never (0)
- Once or twice (2)
- Monthly (3)
- Weekly (4)
- Daily or almost daily (6)

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.25

Question 3: Strong Urge to Use

During the past 3 months, how often have you had a strong desire or urge to use *(first substance, second substance, etc.)?*

- Never (0)
- Once or twice (2)
- Monthly (3)
- Weekly (4)
- Daily or almost daily (6)

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.26

Question 4: Health, Social, Legal, or Financial Problems

- During the past 3 months, how often has your use of *(first substance, second substance, etc.)* led to health, social, legal, or financial problems?
  - Never (0)
  - Once or twice (4)
  - Monthly (5)
  - Weekly (6)
  - Daily or almost daily (7)

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.27

Difficulties/Problems Related to Hazardous, Harmful and Dependent Substance Use

- Physical and mental problems:
  - Decreased immunity to infections
  - Anxiety and depression
  - Sleep problems
- Withdrawal symptoms
- Financial difficulties
- Legal problems
- Relationship problems
- Work problems

3.28

Question 5: Failure to Fulfill Major Role Responsibilities

- During the past 3 months, how often have you failed to do what was normally expected of you because of your use of *(first substance, second substance, etc)?*
  - Never (0)
  - Once or twice (5)
  - Monthly (6)
  - Weekly (7)
  - Daily or almost daily (8)

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.29

Question 6: External Concern

- Has a friend or relative or anyone else ever expressed concern about your use of *(first substance, second substance, etc.)?*
  - No, never (0)
  - Yes, in the past 3 months (6)
  - Yes, but not in the past 3 months (3)

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.30

Break

15 minutes

3.31

Question 7: Failed Attempts to Control Substance Use

Have you ever tried and failed to control, cut down, or stop using *(first substance, second substance, etc.)?*

- No, never (0)
- Yes, in the past 3 months (6)
- Yes, but not in the past 3 months (3)

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.32

Question 8: Injecting Substance Use

- Have you ever used any substance by injection? *(non-medical use only)*
  - No, never (0)
  - Yes, in the past 3 months (2)
  - Yes, but not in the past 3 months (1)
- If yes, query about pattern of injecting

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.33

Pattern of Injecting (if yes to #8)

- Review “risk of injecting” card with client
- Recommend testing for HIV and hepatitis B and C
- Determine:
  - Frequency and pattern of injecting (last 3 months)
  - Whether a referral is warranted

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.34

Pattern of Injecting–Intervention Guidelines

Patterns of Injecting	Intervention Guidelines
Once weekly or less or fewer than 3 days in a row	Brief intervention include "risks associated with injecting" card
More than once per week or 3 or more days in a row	Further assessment and more intensive treatment*

*Specialty SUD treatment

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.35

Feedback Report Card

Specific Substance Involvement Scores

Substance	Score	Risk Level
a. Tobacco products		0–3 Low 4–26 Moderate 27+ High
b. Opioids		0–3 Low 4–26 Moderate 27+ High
c. Cannabis		0–3 Low 4–26 Moderate 27+ High
d. Amphetamine-type stimulants		0–3 Low 4–26 Moderate 27+ High
e. Inhalants		0–3 Low 4–26 Moderate 27+ High
f. Sedatives or sleeping pills		0–3 Low 4–26 Moderate 27+ High
g. Hallucinogens		0–3 Low 4–26 Moderate 27+ High
h. Cocaine		0–3 Low 4–26 Moderate 27+ High
i. Alcoholic beverages		0–3 Low 4–26 Moderate 27+ High
j. Other – specify:		0–3 Low 4–26 Moderate 27+ High

What do your scores mean?

Low: You are at low risk of health and other problems from your current pattern of use.
Moderate: You are at risk of health and other problems from your current pattern of substance use.
High: You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent.

Are you concerned about your substance use?

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.36

Scoring the ASSIST

For each substance (labelled a. to j.), add up the scores received for questions 2 through 7 inclusive. *Do not include the results from either Q1 or Q8 in this score.*

Question 2c	Weekly	Score = 4
Question 3c	Once or Twice	Score = 3
Question 4c	Monthly	Score = 5
Question 5c	Once or twice	Score = 3
Question 6c	Yes, but not in the past 3 months	Score = 3
Question 7c	No, never	Score = 0
Substance Specific Involvement Score for Cannabis		20

Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.37

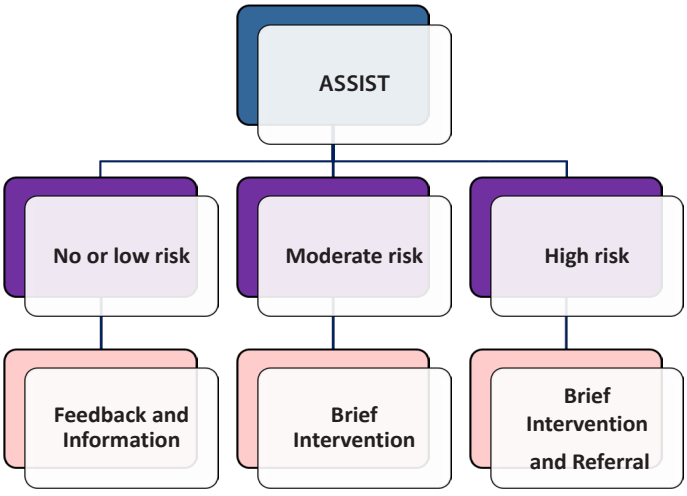
Guidelines for Assessing Risk Level Using the ASSIST

Alcohol	All Other Substances	Risk Level
0–10	0–3	Low risk (feedback + information)
11–26	4–26	Moderate risk (feedback + brief intervention [BI])
27+	27+	High risk (feedback, BI, assessment and referral)

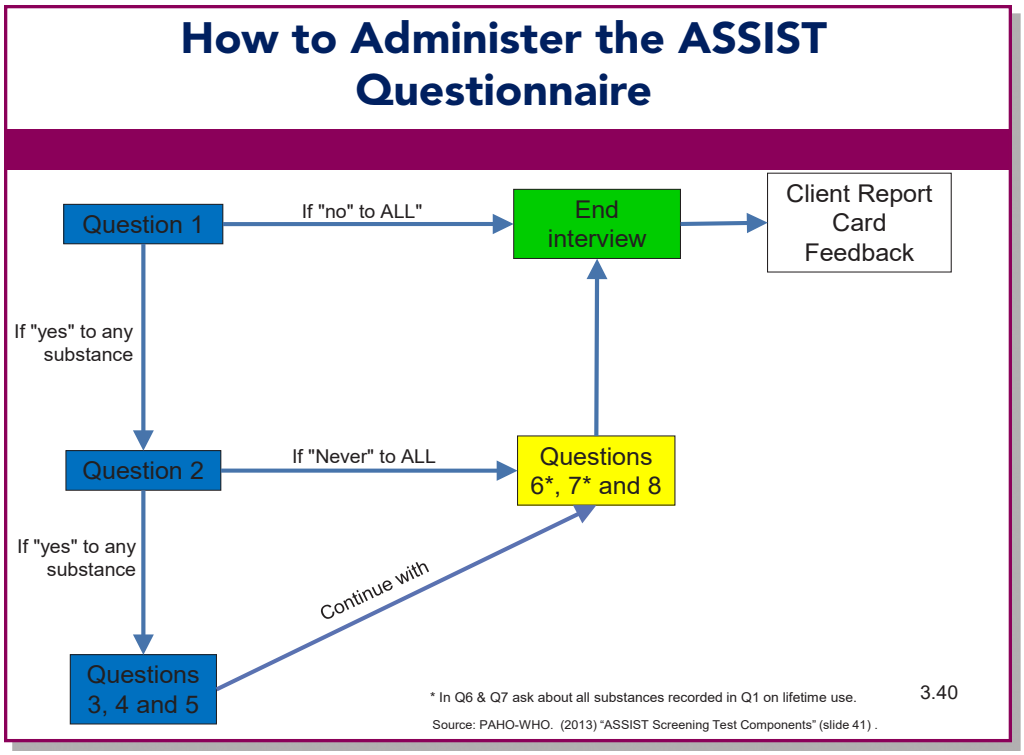
Source: WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

3.38

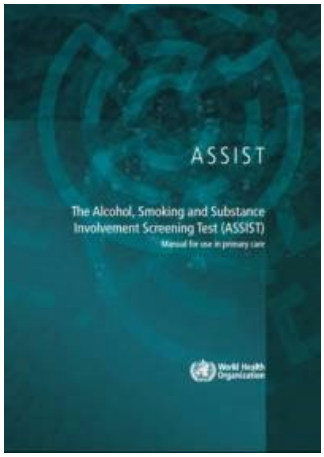
Link ASSIST Score to Appropriate Intervention



3.39


How to Administer the ASSIST Questionnaire
Question 1
If "no" to ALL"
End interview
Client Report Card Feedback
If "yes" to any substance
Question 2
If "Never" to ALL
Questions 6*, 7* and 8
If "yes" to any substance
Continue with
Questions 3, 4 and 5
* In Q6 & Q7 ask about all substances recorded in Q1 on lifetime use.
3.40
Source: PAHO-WHO. (2013) "ASSIST Screening Test Components" (slide 41) .

ASSIST Test Application Protocol



3.41

Introducing the Test

- Show empathy
- Introduce yourself
- Mention the objective
- Briefly describe the ASSIST screening test
- Ensure confidentiality
- Obtain consent

3.42

Presentation

"Good morning, I am …. social worker at the health center ... we have some questions related to your health and lifestyle, which we would like to ask you as part of your consultation ... "

Source: PAHO-WHO. (2013) "ASSIST Screening Test Components" (slide 45) .

3.43

Explain Objective…

"The objective of this test is to identify if the use of some psychoactive substances may be interfering with or could, in the future, cause damage to your health"

3.44

Source: PAHO-WHO. (2013) "ASSIST Screening Test Components" (slide 46) .

Provide Brief Description of the Test…

I have some general questions and then a test of 8 questions which will ask about the use of different psychoactive substances and some problems that may be related to their use... It will take approximately 15 minutes to answer all the questions.

3.45

Source: PAHO-WHO. (2013) "ASSIST Screening Test Components" (slide 47) .

Ensure Confidentiality...

"Since it is also necessary to know if you have used illegal drugs, it is important that you know that all the information you provide is strictly confidential"

Source: PAHO-WHO. (2013) "ASSIST Screening Test Components" (slide 48) .

3.46

Specify Time Period and Scope of Substances to Be Explored

"I will ask you questions about your use of alcohol, tobacco, and other drugs throughout your life and in the past three months."

Provide Instructions: Show Patient Support Sheet

Source: PAHO-WHO. (2013) "ASSIST Screening Test Components" (slide 49) .

3.47

Clarify which Substances are Relevant to the Interview...

"Some of the substances that we discuss may have been prescribed by a doctor; for this interview we will not record the medications you use by prescription. However, if you have used these medications for reasons other than what the doctor indicated, or have taken them with more frequency or in higher doses, please tell me."

Source: PAHO-WHO. (2013) "ASSIST Screening Test Components" (slide 50)

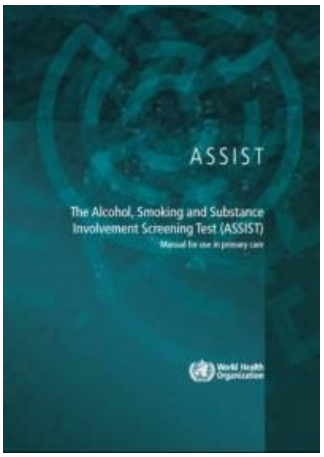
3.48

During the ASSIST....

- Do not show the client what you type
- Record all responses
- Reframe questions that are not understood
- Guide some questions
- Investigate inconsistent responses

3.49

ASSIST Screening Test Interpretation



3.50

Scoring and Interpreting the ASSIST

- Once you have administered the ASSIST, you will get a final score for each of the psychoactive substances considered.
- To obtain this final score, the numerical answers to questions 2 to 7 must be added up.
  - Answers to questions 1 and 8 are NOT included in the final score.
  - In question 5 the answer for tobacco is not recorded, and not included in the final score.
- In this way, "risk scores" will be obtained for each substance, so each client will have 10 risk-level ratings.

Source: PAHO-WHO. (2013) "ASSIST Screening Test Components" (slide 55) .

3.51

Common Mistakes in Scoring ASSIST

- Over-scoring Q3 and Q5. These questions reflect:
  - Dependent use & strong craving (Q3)
  - Loss of control and failure to fulfill obligations (Q5)
- Forgetting that Q1 and Q2 are filter questions:
  - They determine which substance categories to ask about in subsequent questions
- Including Q1 in scoring:
  - Qs 2-7 constitute the substance-specific scores

Source: Treatnet. (2008). *Screening, assessment and treatment planning.* http://www.unodc.org/ddt-training/treatment/a.html

3.52

Day 1 Wrap-up

3.53

UNIVERSAL CURRICULUM
Treatment of Substance Use Disorders

The Universal Treatment Curriculum for Substance Use Disorders (UTC)

UTC 5

Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals

MODULE 3—SCREENING AND BRIEF INTERVENTION

THE COLOMBO PLAN

DAP
Drug Advisory Programme

Partner Exercise: ASSIST Role-Plays

- Practice ASSIST with a partner
- 'Counselor' uses a blank form for the interview
- ‘Client' can use the cases in Resource pages 3.10 and 3.11.
- Score the ASSIST
- Check answers
- Discuss the exercise as a group
- Switch roles and complete the process

3.55

Brief Intervention

- Brief intervention is low-intensity, short-duration counseling
- Effective brief intervention:
  - Uses empathic, respectful approach
  - Incorporates the readiness to change model
  - Includes feedback and advice

Source: Treatnet. (2008). *Screening, assessment and treatment planning.* http://www.unodc.org/ddt-training/treatment/a.html.

3.56

Brief Intervention

- Focuses on increasing a person's insight into and awareness of substance use and behavioral change
- Can be provided through a single session or multiple sessions of motivational interventions by SUD or other professional or peer staff

3.57

Effective Brief Interventions

- Engage clients early
  - Identifying substance use issues early and getting individuals into treatment earlier.
- If referred by a healthcare worker, get the worker's support:
  - May have an established relationship with client
  - May have already warned the client
  - Client may be seeing a healthcare worker frequently
  - Client may view the healthcare worker as being credible
- If self-referred, establish trust

Source: World Health Organization. (2010). *Brief intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use.* Geneva, Switzerland: WHO Press.

3.58

Rationale for Screening and Brief Intervention

- Substance use problems are widespread worldwide
- Substance use problems are associated with significant morbidity and mortality
- Early identification and intervention can result in:
  - A connection of substance use to health issues
  - Identification of problematic substance use
  - Reduction of substance use
  - An admission to treatment

Source: Treatnet. (2008). *Screening, assessment and treatment planning* http://www.unodc.org/ddt-training/treatment/a.html

3.59

Effective Brief Intervention: 5 Components

- Introduce the issue in the context of the client's health
- Screening and assessing
- Provide feedback
- Talk about change and setting goals
- Summarize and reach closure

Source: Treatnet. (2008). *Screening, assessment and treatment planning* http://www.unodc.org/ddt-training/treatment/a.html

3.60

ASSIST: Effective Screening Tool Used in Conjunction With a Brief Intervention

- Substantiates there is a reason for concern
- Provides opportunity for education; early intervention
- Alerts risks for interactions with medication
- Offers opportunity to engage client
- Identifies the need for further evaluation
- Proven to be beneficial in reducing high-risk activities

Source: Treatnet. (2008). *Screening, assessment and treatment planning* http://www.unodc.org/ddt-training/treatment/a.html

3.61

International Study: Benefits of Screening and Brief Intervention (BI)

- ASSIST follow up scores significantly lower than baseline scores
- Brief intervention was effective compared with no intervention in reducing substance use & risk
- BI influenced cutting down, stopping use, thinking about stopping, feeling better
- Study results supported earlier studies that found brief interventions to be cost-effective
- Opportunity to generate "change talk" with the ASSIST appeared to play a significant role in influencing behavior change

3.62

How Is the ASSIST-Linked BI Conducted?

- For clients who have been administered the ASSIST
- Short intervention; 3-15 minutes
- Personalized feedback
- Sharing ASSIST risk scores
- Non-confrontational
- Successful mostly with moderate risk clients

Source: Treatnet. (2008). *Screening, assessment and treatment planning* http://www.unodc.org/ddt-training/treatment/a.html

3.63

FRAMES framework

The components of effective brief interventions can be summarized in the FRAMES framework:

1. Feedback is given to the individual about personal risk or impairment
2. Responsibility for change is placed on the individual
3. Advice to change is given by the provider
4. Menu of alternative self-help or treatment options is offered
5. Empathic style is used in counselling
6. Self-efficacy or optimistic empowerment is engendered.

Source: International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing
World Health Organization and United Nations Office on Drugs and Crime, 2020

3.64

How Is the ASSIST-Linked BI Conducted?

1. Asking clients whether they are interested in seeing their ASSIST scores
2. Providing personalized feedback using the ASSIST feedback report card
3. Giving advice about how to reduce risk associated with substance use
4. Allowing clients to take ultimate responsibility for their choices
5. Asking clients how concerned they are about their scores

Source: WHO. (2010). *Brief intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use.* Geneva: WHO Press.

3.65

The Next 5 Steps in Conducting the ASSIST-Linked BI

6. Weighing the **good things** about using substance
7. Weighing the **less good things** about using substance
8. **Summarizing and reflecting** on clients' emphasis on "less good things"
9. Asking clients how **concerned** they are about "less good things"
10. Giving clients **take-home materials**

Source: WHO. (2010). *Brief intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use.* Geneva: WHO Press.

3.66

Steps 1 and 2: Ask and Give Feedback

- Start the conversation by **asking** if they want to see the results of the ASSIST
- Use the report card to provide **feedback** to the client:

"I'd like to share with you the results of the questionnaire you just completed. These are your scores for each substance that we talked about. You scored a 14 for alcohol, which puts you in the moderate risk group for that substance. You scored in the low-risk group for all other substances."

Source: WHO. (2010). *Brief intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use.* Geneva: WHO Press.

3.67

Step 3: Offer Advice

- "The best way to reduce your risk of alcohol-related harm is to cut back on your use, that is to move from this moderate risk category (point to report card) back to the low-risk category (point)."

Source: WHO. (2010). *Brief intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use*. Geneva: WHO Press.

3.68

Steps 4 and 5: Place Responsibility on the Client and Elicit Client Concern

- "What you do with the information is up to you. I am here to assist you if you would like help cutting back on your use."
- "What are your thoughts about your scores, particularly the one for alcohol?"

Take note and reflect back client's "change talk"

Source: WHO. (2010). *Brief intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use*. Geneva: WHO Press.

3.69

Steps 6 and 7: Encourage Client to Weigh the Benefits and Costs

- "What are some **good things** about using ___ for you personally?"
- "What are some of the **not-so-good things**?"
- "What are some of your **concerns** about these not-so-good things?"

3.70

Step 8: Summarize and Reflect on the "Not-So-Good" Things

"OK, so on the one hand, you have mentioned a lot of good things about getting drunk – you have a great time at parties, you are not so inhibited around your friends, everyone thinks you are the life of the party. But on the other hand, you have missed a lot of class time, your grades are suffering, and school is very important to you."

(Summarize by developing a discrepancy)

Source: Treatnet. (2008). *Screening, assessment and treatment planning.* http://www.unodc.org/ddt-training/treatment/a.html.

3.71

Step 9: Ask How Concerned Client Is About "Not-So-Good" Things

- Ask open-ended questions
- Follow up on discrepancy developed in Step #8:

"Do the things we just talked about (missing classes and getting poor grades) concern you? Tell me how."

Source: World Health Organization. (2010). *Brief intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use.* Geneva, Switzerland: WHO Press.

3.72

Step 10: Provide Take-Home Materials

- ASSIST feedback report card
- General information pamphlets on the substance being used
- Self-help strategies for cutting down or stopping substance use
- Risks of injecting card (if relevant)

Source: World Health Organization. (2010). *Brief intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use.* Geneva, Switzerland: WHO Press.

3.73

Making Referrals For Further Assessment and Treatment

- Clients who have high scores on the ASSIST (high-risk clients) should receive a referral to specialized treatment in addition to a brief intervention. Be prepared to make referrals for further assessment and treatment:
  - Giving a phone number is not enough
  - Become familiar with local community resources
  - Take a proactive role in learning about the availability of appointments or treatment slots, costs, and transportation
  - Get names of contact persons at each program

3.74

Encourage Follow-up Visits

- Inquire about use
- Review goals and progress
- Reinforce and motivate
- Review tips for progress

Treatnet. (2008). *Screening, assessment and treatment planning.* http://www.unodc.org/ddt-training/treatment/a.html

3.75

Break

15 minutes

3.76

Small-Group Exercise: ASSIST-linked Brief Intervention Role-play

- Group of 3: Interviewer, client and observer
- Client: Role play your own case (Use the ASSIST score from the previous exercise)
- Interviewer:
  - Conduct the entire ASSIST linked Brief Intervention
  - Follow the 10 steps of ASSIST linked Brief Intervention
  - Initiate and complete the entire ASSIST linked Brief Intervention
  - Show empathy and warmth
- Observer: Takes notes for the feedback

3.77

Reflective Exercise: Summarizing the Effective Use of the ASSIST in BI

- What are some of the advantages of an ASSIST-linked brief intervention?
- How does a brief intervention differ for clients who are deemed moderate risks versus those deemed to be high risk?
- What are the 10 steps followed in an ASSIST-linked brief intervention?
- What take-home materials would you want to have available at your treatment program as a means of bolstering a brief intervention?

3.78

Resource Page 3.1: ASSIST Definitions of Hazardous, Harmful and Dependence

The ASSIST definitions are as follows:

- Hazardous use is a pattern of use that increases the risk of negative consequences for the person. For example, someone who smokes marijuana and then drives;
- Harmful use is a pattern of use that is damaging to the physical and/or mental health of the person. For example, someone who uses substances heavily on weekends or gets high on substances every day; and,
- Dependence on substances usually develops after repeated use and involves a cluster of symptoms that can include a strong desire to use the substance, impaired control over its use, persistent use of the substance even when it is causing harm, increased tolerance to the effects of the substance, and a withdrawal reaction when use is stopped or reduced.

Hazardous, harmful, or dependent-use patterns of psychoactive substances can also cause significant social problems for the person, such as problems with family, friends, the law, and finances.

Resource Page 3.2: ASSIST V3.1 (Adapted from the original version)[1]

Appendix A

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST v3.1)

Clinician Name		Clinic	
Client ID or Name		Date	

Introduction (please read to client or adapt for local circumstances)*

The following questions ask about your experience of using alcohol, tobacco products and other drugs across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled or injected (show response card).

*Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will **not** record medications that are used **as prescribed** by your doctor. However, if you have taken such medications for reasons **other** than prescription, or taken them more frequently or at higher doses than prescribed, please let me know.*

While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Before asking questions, give ASSIST response card to client

QUESTION 1 | In your life, which of the following substances have you *ever used* (non-medical use only)?		
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	No	Yes
b Alcoholic beverages (beer, wine, spirits, etc.)	No	Yes
c Cannabis (marijuana, pot, grass, hash, etc.)	No	Yes
d Cocaine (coke, crack, etc.)	No	Yes
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	No	Yes
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	No	Yes
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	No	Yes
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	No	Yes
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	No	Yes
j Other – specify: _____	No	Yes
Probe if all answers are negative: "Not even when you were in school?"	If "No" to all items, stop interview. If "Yes" to any of these items, ask Q2 for each substance ever used	

* ASSIST V3.1 is to be utilized by for screening in clinical settings. For research purposes please use the previous version ASSIST V3.0.

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QUESTION 2 | In the *past three months*, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d Cocaine (coke, crack, etc.)	0	2	3	4	6
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	2	3	4	6
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	2	3	4	6
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	2	3	4	6
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	2	3	4	6
j Other – specify: _____	0	2	3	4	6

If "Never" to all items in Q2, skip to Q6.

If any substances in Q2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

QUESTION 3 | During the *past three months*, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d Cocaine (coke, crack, etc.)	0	3	4	5	6
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	3	4	5	6
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	3	4	5	6
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	3	4	5	6
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	3	4	5	6
j Other – specify: _____	0	3	4	5	6

QUESTION 4 | During the *past three months*, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d Cocaine (coke, crack, etc.)	0	4	5	6	7
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	4	5	6	7
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	4	5	6	7
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	4	5	6	7
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	4	5	6	7
j Other – specify: _____	0	4	5	6	7

QUESTION 5 | During the *past three months*, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a Tobacco products					
b Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d Cocaine (coke, crack, etc.)	0	5	6	7	8
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	5	6	7	8
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	5	6	7	8
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	5	6	7	8
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	5	6	7	8
j Other – specify: _____	0	4	5	6	7
Ask questions 6 & 7 for all substances ever used (i.e. those endorsed in Q1).					

QUESTION 6 | Has a friend or relative or anyone else *ever* expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d Cocaine (coke, crack, etc.)	0	6	3
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	6	3
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	6	3
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	6	3
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	6	3
j Other – specify: _____	0	6	3
Ask questions 6 & 7 for all substances ever used (i.e. those endorsed in Q1).			

QUESTION 7 | Have you *ever* tried to cut down on using (first drug, second drug, etc) but failed?	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d Cocaine (coke, crack, etc.)	0	6	3
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	0	6	3
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	0	6	3
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	0	6	3
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	0	6	3
j Other – specify: _____	0	6	3
Ask questions 6 & 7 for all substances ever used (i.e. those endorsed in Q1).			

QUESTION 8 | Have you *ever* used any drug by injection (non-medical use only)?	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
(Please tick the appropriate box)			

IMPORTANT NOTE

Clients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

Pattern of injecting	Intervention guidelines
4 days per month, on average, over the last 3 months or less	Brief intervention including the risks of injecting card
More than 4 days per month, on average, over the last 3 months	Further assessment and more intensive treatment

How to calculate a specific substance involvement score.

For each substance (labelled 'a' to 'j') add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c.**

Note that Q5 for tobacco is not coded, and is calculated as: **Q2a + Q3a + Q4a + Q6a + Q7a.**

The type of intervention is determined by the patient's specific substance involvement score				
	Record specific substance score	**No intervention**	**Receive brief intervention**	**More intensive treatment**
a Tobacco		0 – 3	4 – 26	27+
b Alcohol		0 – 10	11 – 26	27+
c Cannabis		0 – 3	4 – 26	27+
d Cocaine		0 – 3	4 – 26	27+
e ATS		0 – 3	4 – 26	27+
f Inhalants		0 – 3	4 – 26	27+
g Sedatives		0 – 3	4 – 26	27+
h Hallucinogens		0 – 3	4 – 26	27+
i Opioids		0 – 3	4 – 26	27+
j Other drugs		0 – 3	4 – 26	27+
Now use ASSIST feedback report card to give client brief intervention.				

Appendix B

ASSIST v3.1 response card

RESPONSE CARD | Substances
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b Alcoholic beverages (beer, wine, spirits, etc.)
c Cannabis (marijuana, pot, grass, hash, etc.)
d Cocaine (coke, crack, etc.)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)
j Other – specify: _____

RESPONSE CARD | Frequency responses	
Response card **Last 3 months (ASSIST questions 2 to 5)**	**Response card** **Lifetime (ASSIST questions 6 to 8)**
▮ **Never:** not used in the last 3 months. ▮ **Once or twice:** 1 to 2 times in the last 3 months. ▮ **Monthly:** average of 1 to 3 times per month over the last 3 months. ▮ **Weekly:** 1 to 4 times per week. ▮ **Daily or almost daily:** 5 to 7 days per week.	▮ **No, never.** ▮ **Yes, but not in the past 3 months.** ▮ **Yes, in the past 3 months.**

Appendix C

ASSIST v3.1 feedback report card

Client ID or Name _____ Date _____

Specific substance involvement scores	Score	Risk Level	
a Tobacco products		0 – 3 4 – 26 27+	Lower Moderate High
b Alcoholic beverages		0 – 10 11 – 26 27+	Lower Moderate High
c Cannabis		0 – 3 4 – 26 27+	Lower Moderate High
d Cocaine		0 – 3 4 – 26 27+	Lower Moderate High
e Amphetamine-type stimulants		0 – 3 4 – 26 27+	Lower Moderate High
f Inhalants		0 – 3 4 – 26 27+	Lower Moderate High
g Sedatives or sleeping pills		0 – 3 4 – 26 27+	Lower Moderate High
h Hallucinogens		0 – 3 4 – 26 27+	Lower Moderate High
i Opioids		0 – 3 4 – 26 27+	Lower Moderate High
j Other – specify: _____		0 – 3 4 – 26 27+	Lower Moderate High

What do your scores mean?

Lower: You are at lower risk of health and other problems from your current pattern of use.

Moderate: You are at moderate risk of health and other problems from your current pattern of substance use.

High: You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent.

Are you concerned about your substance use?

A | Tobacco		
Your risk of experiencing these harms is (tick one):		
Lower ☐	Moderate ☐	High ☐
Regular tobacco smoking is associated with:		
Premature ageing and wrinkling of the skin		
Low fitness and longer recovery times after having a cold or flu		
Respiratory infections and asthma		
High blood pressure and diabetes mellitus		
Miscarriage, premature labour and low birth weight babies for pregnant women		
Kidney disease		
Chronic obstructive pulmonary diseases including emphysema		
Heart disease, stroke and vascular diseases		
Cancers of lung, bladder, breast, mouth, throat and oesophagus		

B | Alcohol		
Your risk of experiencing these harms is (tick one):		
Lower ☐	Moderate ☐	High ☐
Regular exessive alcohol use is associated with:		
Hangovers, aggressive and violent behaviour, accidents and injury, nausea and vomiting		
Reduced sexual performance and premature ageing		
Digestive problems, ulcers, inflammation of the pancreas and high blood pressure		
Anxiety and depression, relationship difficulties, and financial and work problems		
Difficulty remembering things and solving problems		
Birth defects and brain damage in babies of pregnant women		
Permanent brain damage leading to memory loss, cognitive deficits and disorientation		
Stroke, muscle and nerve damage		
Liver and pancreas diseases		
Cancers of the mouth, throat and breast		
Suicide		

C | Cannabis		
Your risk of experiencing these harms is (tick one):		
Lower ☐	Moderate ☐	High ☐
Regular use of cannabis is associated with:		
Problems with attention and motivation		
Anxiety, paranoia, panic and depression		
Decreased memory and problem solving ability		
High blood pressure		
Asthma and bronchitis		
Psychotic symptoms and psychoses particularly in those with a personal or family history of schizophrenia		
Heart disease and chronic obstructive pulmonary disease		
Cancers of the upper airway and throat		

D | Cocaine		
Your risk of experiencing these harms is (tick one):		
Lower ☐	Moderate ☐	High ☐
Regular use of cocaine is associated with:		
Difficulty sleeping, heart racing, headaches and weight loss		
Numbness, tingling, clammy skin and skin scratching or picking		
Intense craving and stress from the lifestyle		
Accidents and injury and financial problems		
Mood swings – anxiety, depression and mania		
Paranoia, irrational thoughts and difficulty remembering things		
Aggressive and violent behaviour		
Psychosis after repeated use of high doses		
Sudden death from cardiovascular acute conditions		

E | Amphetamine-type stimulants		
Your risk of experiencing these harms is (tick one):		
Lower ☐	Moderate ☐	High ☐
Regular use of amphetamine-type stimulants is associated with:		
Difficulty sleeping, loss of appetite and weight loss, dehydration and reduced resistance to infection		
Jaw clenching, headaches and muscle pain		
Mood swings –anxiety, depression, agitation, mania and panic		
Tremors, irregular heartbeat and shortness of breath		
Difficulty concentrating and remembering things		
Paranoia, aggressive and violent behaviour		
Psychosis after repeated use of high doses		
Permanent damage to brain cells		
Liver damage, brain haemorrhage and sudden death from cardiovascular acute conditions		

F | Inhalants		
Your risk of experiencing these harms is (tick one):		
Lower ☐	Moderate ☐	High ☐
Regular use of inhalant is associated with:		
Flu like symptoms, sinusitis and nosebleeds		
Nausea and vomiting, indigestion, stomach ulcers and diarrhoea		
Dizziness and hallucinations, nausea, drowsiness, disorientation and blurred vision		
Headaches, accidents and injury, unpredictable and dangerous behaviour		
Coordination difficulties, slowed reactions and poor oxygen supply to the body		
Memory loss, confusion, depression, aggression and extreme tiredness		
Delirium, seizures, coma and organ damage (heart, lungs, liver, kidneys)		
Death from heart failure		

G | Sedatives or sleeping pills		
Your risk of experiencing these harms is (tick one):		
Lower ☐	Moderate ☐	High ☐
Regular use of sedatives is associated with:		
Drowsiness, dizziness and confusion		
Difficulty concentrating and remembering things		
Nausea, headaches and unsteady gait		
Sleeping problems		
Anxiety and depression		
Tolerance and dependence after a short period of use		
Severe withdrawal symptoms		
Overdose and death if used with alcohol, opioids or other depressant drugs		

H | Hallucinogens		
Your risk of experiencing these harms is (tick one):		
Lower ☐	Moderate ☐	High ☐
Regular use of hallucinogens is associated with:		
Visual, auditory, tactile and olfactory changes and unpredictable behaviour		
Difficulty sleeping		
Nausea and vomiting		
Increased heart rate and blood pressure		
Mood swings		
Anxiety, panic and paranoia		
Flash-backs		
Worsen the symptoms of mental illnesses such as schizophrenia		

I | Opioids		
Your risk of experiencing these harms is (tick one):		
Lower ☐	Moderate ☐	High ☐
Regular use of opioids is associated with:		
Itching, nausea and vomiting		
Drowsiness, constipation, tooth decay and irregular menstrual periods		
Difficulty concentrating and remembering things		
Depression, reduced libido and impotence		
Financial difficulties and criminal offences		
Relationship stress		
Problems maintaining work and family life		
Tolerance, dependence and withdrawal symptoms		
Overdose and death from respiratory failure		

Appendix D

ASSIST risks of injecting card | Information for clients

Using substances by injection increases the risk of harm from substance use

This harm can come from:

- The substance:
  - If you inject any drug you are more likely to become dependent.
  - If you inject amphetamines or cocaine you are more likely to experience psychosis.
  - If you inject heroin or other sedatives you are more likely to overdose.
- The injecting behaviour:
  - If you inject you may damage your skin and veins and get infections.
  - You may cause scars, bruises, swelling, abscesses and ulcers.
  - Your veins might collapse.
  - If you inject into the neck you can cause a stroke.
- Sharing of injecting equipment:
  - If you share injecting equipment (needles & syringes, spoons, filters, etc.) you are more likely to spread bloodborne virus infections like hepatitis B and C and HIV.

It is less risky not to inject

If you do inject:

- always use clean equipment (e.g., needles & syringes, spoons, filters, etc.)
- always use a new needle and syringe
- don't share equipment with other people
- clean the preparation area
- clean your hands
- clean the injecting site
- use a different injecting site each time
- inject slowly
- put your used needle and syringe in a hard container and dispose of it safely.

- If you use stimulant drugs like amphetamines or cocaine the following tips will help you reduce your risk of psychosis:
  - avoid injecting and smoking
  - avoid using on a daily basis.
- If you use depressant drugs like heroin the following tips will help you reduce your risk of overdose:
  - avoid using other drugs, especially sedatives or alcohol, on the same day
  - use a small amount and always have a trial "taste" of a new batch
  - have someone with you when you are using
  - avoid injecting in places where no-one can get to you if you do overdose
  - know the telephone numbers of the ambulance service.

Appendix E

Translation and adaptation to local languages and culture: a resource for clinicians and researchers

The ASSIST instrument, instructions, drug cards, response scales and resource manuals may need to be translated into local languages for use in particular countries or regions. Translation from English should be as direct as possible to maintain the integrity of the tools and documents. However, in some cultural settings and linguistic groups, aspects of the ASSIST and its companion documents may not be able to be translated literally and there may be socio-cultural factors that will need to be taken into account in addition to semantic meaning. In particular, substance names may require adaptation to conform to local conditions, and it is also worth noting that the definition of a standard drink may vary from country to country.

Translation should be undertaken by a bilingual translator, preferably a health professional with experience in interviewing. For the ASSIST instrument itself, translations should be reviewed by a bilingual expert panel to ensure that the instrument is not ambiguous. Back translation into English should then be carried out by another independent translator whose main language is English to ensure that no meaning has been lost in the translation. This strict translation procedure is critical for the ASSIST instrument to ensure that comparable information is obtained wherever the ASSIST is used across the world.

Translation of this manual and companion documents may also be undertaken if required. These do not need to undergo the full procedure described above, but should include an expert bilingual panel.

Before attempting to translate the ASSIST and related documents into other languages, interested individuals should consult with the WHO about the procedures to be followed and the availability of other translations. Contact WHO at:

Management of Substance Abuse, Department of Mental Health and Substance Abuse
World Health Organization
20 Avenue Appia
1211 Geneva 27, Switzerland

Telephone: +41 22 791 3494
Fax: +41 22 791 4851
E-mail: msb@who.int
Website: www.who.int/substance_abuse/activities/assist/en/

Appendix F

Answers to self-testing questions from Chapter 11

SELF-TESTING | Answers	
1 Q2. Someone who had used heroin twice in the last three months would be coded as… ?	Once or twice = 2
2 Q2. Someone who drank alcohol every day of the week except Mondays in the last 3 months would be coded as… ?	Daily/almost daily = 6
3 Q2. Someone who smoked marijuana 3 to 4 times per week in the last 3 months would be coded as… ?	Weekly = 4
4 Q2. Someone who uses cocaine once a fortnight would be coded as… ?	Monthly = 3
5 Q2. Someone who smoked cigarettes everyday but has been abstinent for the last 6 weeks would be coded as… ?	Weekly = 4
6 Q2. Someone who used methamphetamine 3 times in the last 3 months would be coded as… ?	Monthly = 3

Appendix G

Two client scripts ('Chloe' and 'Dave')

Instructions for paired role play

This paired role-play can be used to help you practice correct administration of the ASSIST. It is also a valuable exercise to help you understand what it is like for a client to be administered the ASSIST questionnaire. Two people are required for the activity; one person to play the interviewer, and one person to play the client. You will also need the ASSIST v3.1 questionnaire and ASSIST response card for this activity.

The person who is administering the ASSIST questionnaire (interviewer) uses a blank ASSIST questionnaire to record the client's responses. The ASSIST introduction, which is provided on the front page of the ASSIST questionnaire, should also read or paraphrased as part of the role-play, and the ASSIST response card given to the client.

The person who is playing the client reads this script in response to interviewer's questions. The script must be read **as written**, as any changes may result in erroneous coding and scoring by interviewer.

Following administration of the ASSIST questionnaire, the interviewer should calculate the client's final scores and record them in the box on the last page of the ASSIST v3.1 questionnaire. The scores calculated by the interviewer should be compared with the correct scores provided on the back page of this script. If there are any differences, they should be discussed and resolved by the role-play pair, so that the final scores obtained by the interviewer reflect the scores provided on this script.

NOTE TO PERSON READING CLIENT SCRIPT
Some of your responses have brackets around them (e.g. Q2d.). This means that the interviewer should not have asked you this question due to filtering out. The answer written in brackets may still be provided to the interviewer, along with feedback to remind them that they did not need to ask you this question.

Client script ASSIST v3.1 (Chloe)
Responses for paired role play

QUESTION 1 | In your life, which of the following substances have you *ever used* (non-medical use only)?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	Yes
b Alcoholic beverages (beer, wine, spirits, etc.)	Yes
c Cannabis (marijuana, pot, grass, hash, etc.)	Yes
d Cocaine (coke, crack, etc.)	No
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	Yes
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	Yes
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	Yes
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	No
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	No
j Other – specify: _____	No

QUESTION 2 | In the *past three months*, how often have you used the substances you mentioned (first drug, second drug, etc)?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc)	Every day
b Alcoholic beverages (beer, wine, spirits, etc.)	Every day
c Cannabis (marijuana, pot, grass, hash, etc.)	Once or twice
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	About once a week
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	I've used nitrous oxide twice
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	Haven't used them in the last 3 months
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	(Never tried hallucinogens)
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	(Never tried opioids)
j Other – specify: _____	(Never tried other drugs)

QUESTION 3 | During the *past three months*, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc)	Every day
b Alcoholic beverages (beer, wine, spirits, etc.)	I've had some desire to drink but I wouldn't say a strong desire so I would have to say never in the last 3 months
c Cannabis (marijuana, pot, grass, hash, etc.)	Never
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	Probably have had a really strong craving for speed once or twice in the last 3 months
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	Never
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	(Haven't used them in last 3 months)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	(Never tried hallucinogens)
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	(Never tried opioids)
j Other – specify: _____	(Never tried other drugs)

QUESTION 4 | During the *past three months*, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc)	Once or twice in the last 3 months I've noticed that I have been really out of breath after exercise and I think its because of smoking
b Alcoholic beverages (beer, wine, spirits, etc.)	I've had really bad hangovers on average about once every fortnight in the last 3 months
c Cannabis (marijuana, pot, grass, hash, etc.)	Never
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	I've run out of money twice in the last three months because of buying speed and I've had some problems paying my bills
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	Never
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	(Haven't used them in last 3 months)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	(Never tried hallucinogens)
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	(Never tried opioids)
j Other – specify: _____	(Never tried other drugs)

QUESTION 5 | During the *past three months*, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	
a Tobacco products	
b Alcoholic beverages (beer, wine, spirits, etc.)	Never
c Cannabis (marijuana, pot, grass, hash, etc.)	Never
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	Never
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	Never
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	(Haven't used them in last 3 months)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	(Never tried hallucinogens)
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	(Never tried opioids)
j Other – specify: _____	(Never tried other drugs)

QUESTION 6 | Has a friend or relative or anyone else *ever* expressed concern about your use of (first drug, second drug, etc)?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc)	Yes, my doctor said I should stop smoking about a year ago, but not since then
b Alcoholic beverages (beer, wine, spirits, etc.)	Yes, but not in the past 3 months
c Cannabis (marijuana, pot, grass, hash, etc.)	Never
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	Yes, my boyfriend did last month
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	Never
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	Yes, but not in the past 3 months
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	(Never tried hallucinogens)
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	(Never tried opioids)
j Other – specify: _____	(Never tried other drugs)

QUESTION 7 | Have you *ever* tried to cut down on using (first drug, second drug, etc) but failed?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc)	Yes, I've tried in the last 3 months but I haven't been successful
b Alcoholic beverages (beer, wine, spirits, etc.)	Never tried
c Cannabis (marijuana, pot, grass, hash, etc.)	Never
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	Never
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	Never
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	I used to use a lot of Valium and had to cut down on it but I was successful the first time
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	(Never tried hallucinogens)
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	(Never tried opioids)
j Other – specify: _____	(Never tried other drugs)

QUESTION 8 | Have you *ever* used any drug by injection (non-medical use only)?	Never

The type of intervention is determined by the patient's specific substance involvement score				
	Record specific substance score	No intervention	Receive brief intervention	More intensive treatment
a Tobacco	25	0 – 3	4 – 26	27+
b Alcohol	14	0 – 10	11 – 26	27+
c Cannabis	2	0 – 3	4 – 26	27+
d Cocaine	0	0 – 3	4 – 26	27+
e ATS	17	0 – 3	4 – 26	27+
f Inhalants	2	0 – 3	4 – 26	27+
g Sedatives	3	0 – 3	4 – 26	27+
h Hallucinogens	0	0 – 3	4 – 26	27+
i Opioids	0	0 – 3	4 – 26	27+
j Other drugs	0	0 – 3	4 – 26	27+

Role play Chloe's scoring								
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Total
a Tobacco	Yes	Daily 6	Daily 6	O-T 4	NA	Y/N 3m 3	Y 3m 6	25
b Alcohol	Yes	Daily 6	Never 0	Monthly 5	Never 0	Y/N 3m 3	Never 0	14
c Cannabis	Yes	O-T 2	Never 0	Never 0	Never 0	Never 0	Never 0	2
d Cocaine	No	Never 0	Never 0	Never 0	Never 0	Never 0	Never 0	0
e ATS	Yes	Weekly 4	O-T 3	O-T 4	Never 0	Y 3m 6	Never 0	17
f Inhalants	Yes	O-T 2	Never 0	Never 0	Never 0	Never 0	Never 0	2
g Sedatives	Yes	Never 0	Never 0	Never 0	Never 0	Y/N 3m 3	Never 0	3
h Hallucinogens	No	Never 0	Never 0	Never 0	Never 0	Never 0	Never 0	0
i Opioids	No	Never 0	Never 0	Never 0	Never 0	Never 0	Never 0	0
j Other drugs	No	Never 0	Never 0	Never 0	Never 0	Never 0	Never 0	0

IMPORTANT NOTE

'Y/N 3m' means; "Yes, but not in the past 3 months" (score of 3).

'O-T' means; "Once or Twice".

'Y 3m' means; "Yes, in the past 3 months" (score of 6).

Q1 and Q8 are not included in the scoring.

Client script WHO | ASSIST v3.1 (Dave)
Responses for paired role play

QUESTION 1 | In your life, which of the following substances have you *ever used* (non-medical use only)?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	Yes
b Alcoholic beverages (beer, wine, spirits, etc.)	Yes
c Cannabis (marijuana, pot, grass, hash, etc.)	Yes
d Cocaine (coke, crack, etc.)	No
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	Yes
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	No
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	No
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	Yes
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	Yes
j Other – specify: _____	Yes, I've tried kava

QUESTION 2 | In the *past three months*, how often have you used the substances you mentioned (first drug, second drug, etc)?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc)	Every day
b Alcoholic beverages (beer, wine, spirits, etc.)	Once or twice
c Cannabis (marijuana, pot, grass, hash, etc.)	Pretty much every day
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	Not in the last 3 months
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	(Never tried inhalants)
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	(Never tried sedatives)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	I've had a couple trips in the last 3 months (twice)
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	I used to be addicted to heroin and made several attempts to cut down, but I managed to stop using completely about 3 years ago – so I haven't used any opioids in the last 3 months
j Other – specify: kava	Only tried kava once years ago, haven't used since

QUESTION 3 | During the *past three months*, how often have you had a strong desire or urge to use(first drug, second drug, etc)?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc)	Every day
b Alcoholic beverages (beer, wine, spirits, etc.)	Never
c Cannabis (marijuana, pot, grass, hash, etc.)	Every day
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	(Haven't used last 3 months)
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	(Never tried inhalants)
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	(Never tried sedatives)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	Never
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	(Haven't used last 3 months)
j Other – specify: kava	(Haven't used last 3 months)

QUESTION 4 | During the *past three months*, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc)	I wake up with a really bad cough once or twice a week. I've been like that for about 2 years
b Alcoholic beverages (beer, wine, spirits, etc.)	Never
c Cannabis (marijuana, pot, grass, hash, etc.)	Last month the police gave me a caution for possessing marijuana, but nothing else really
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	(Haven't used last 3 months)
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	(Never tried inhalants)
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	(Never tried sedatives)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	Never
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	(Haven't used last 3 months)
j Other – specify: kava	(Haven't used last 3 months)

QUESTION 5 | During the *past three months*, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	
a Tobacco products	
b Alcoholic beverages (beer, wine, spirits, etc.)	Never
c Cannabis (marijuana, pot, grass, hash, etc.)	Two months ago I forgot to attend an important family event because I was smoking marijuana all day. My family were very angry at me because of it.
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	(Haven't used last 3 months)
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	(Never tried inhalants)
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	(Never tried sedatives)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	Never
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	(Haven't used last 3 months)
j Other – specify: kava	(Haven't used last 3 months)

QUESTION 6 | Has a friend or relative or anyone else *ever* expressed concern about your use of (first drug, second drug, etc)?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc)	Yes, but not in the past 3 months
b Alcoholic beverages (beer, wine, spirits, etc.)	Never
c Cannabis (marijuana, pot, grass, hash, etc.)	Yes, about 6 months ago
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	Never
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	(Never tried inhalants)
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	(Never tried sedatives)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	Never
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	Yes, but it was years ago
j Other – specify: kava	Never

QUESTION 7 | Have you *ever* tried to cut down on using (first drug, second drug, etc) but failed?	
a Tobacco products (cigarettes, chewing tobacco, cigars, etc)	Yes, I tried last month but failed
b Alcoholic beverages (beer, wine, spirits, etc.)	Never had to
c Cannabis (marijuana, pot, grass, hash, etc.)	I've never tried to stop
d Cocaine (coke, crack, etc.)	(Never tried coke)
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	Never been a problem
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	(Never tried inhalants)
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	(Never tried sedatives)
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	Never had to
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	Yes, but not in the past 3 months
j Other – specify: kava	Only used once, so no never

QUESTION 8 | Have you *ever* used any drug by injection (non-medical use only)?	Yes, but not in the past 3 months

The type of intervention is determined by the patient's specific substance involvement score				
	Record specific substance score	No intervention	Receive brief intervention	More intensive treatment
a Tobacco	27	0 – 3	4 – 26	27+
b Alcohol	2	0 – 10	11 – 26	27+
c Cannabis	24	0 – 3	4 – 26	27+
d Cocaine	0	0 – 3	4 – 26	27+
e ATS	0	0 – 3	4 – 26	27+
f Inhalants	0	0 – 3	4 – 26	27+
g Sedatives	0	0 – 3	4 – 26	27+
h Hallucinogens	2	0 – 3	4 – 26	27+
i Opioids	6	0 – 3	4 – 26	27+
j Other drugs	0	0 – 3	4 – 26	27+

Role play Dave's scoring								
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Total
a Tobacco	Yes	Daily 6	Daily 6	Weekly 6	NA	Y/N 3m 3	Y 3m 6	27
b Alcohol	Yes	O-T 2	Never 0	Never 0	Never 0	Never 0	Never 0	2
c Cannabis	Yes	Daily 6	Daily 6	O-T 4	O-T 5	Y/N 3m 3	Never 0	24
d Cocaine	No	Never 0	Never 0	Never 0	Never 0	Never 0	Never 0	0
e ATS	Yes	Never 0	Never 0	Never 0	Never 0	Never 0	Never 0	0
f Inhalants	No	Never 0	Never 0	Never 0	Never 0	Never 0	Never 0	0
g Sedatives	No	Never 0	Never 0	Never 0	Never 0	Never 0	Never 0	0
h Hallucinogens	Yes	O-T 2	Never 0	Never 0	Never 0	Never 0	Never 0	2
i Opioids	Yes	Never 0	Never 0	Never 0	Never 0	Y/N 3m 3	Y/N 3m 3	6
j Other drugs	Yes	Never 0	Never 0	Never 0	Never 0	Never 0	Never 0	0

IMPORTANT NOTE

'Y/N 3m' means; "Yes, but not in the past 3 months" (score of 3).

'O-T' means; "Once or Twice".

'Y 3m' means; "Yes, in the past 3 months" (score of 6).

Q1 and Q8 are not included in the scoring.

Resource Page 3.3: Current Calendar[1]

JANUARY						
M	T	W	T	F	S	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23/30	24/31	25	26	27	28	29

FEBRUARY						
M	T	W	T	F	S	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

MARCH						
M	T	W	T	F	S	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL						
M	T	W	T	F	S	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY						
M	T	W	T	F	S	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE						
M	T	W	T	F	S	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY						
M	T	W	T	F	S	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24/31	25	26	27	28	29	30

AUGUST						
M	T	W	T	F	S	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER						
M	T	W	T	F	S	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER						
M	T	W	T	F	S	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23/30	24/31	25	26	27	28	29

NOVEMBER						
M	T	W	T	F	S	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

DECEMBER						
M	T	W	T	F	S	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

[1] WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

Resource Page 3.4: ASSIST Role-Play Case Study #1: Noor[1]

Noor is a client being interviewed using the ASSIST. To answer questions 1 and 2, use the following information about substance use in the last 3 months:

- Tobacco products: every day
- Opioids: never tried opioids
- Cannabis: 1 or 2 times
- Cocaine: never tried coke
- Amphetamine-type stimulants: about once a week
- Inhalants: nitrous oxide twice
- Sedatives: haven't used in the last 3 months
- Alcoholic beverages: every day
- Other: never tried other drugs

For answers to question #3, use the following information about strong desire to use in the last 3 months:

- Tobacco products: every day
- Opioids: never tried opioids
- Cannabis: no desire
- Cocaine: never tried coke
- Amphetamine-type stimulants: strong cravings for speed once or twice
- Inhalants: no desire
- Sedatives: haven't used in the last 3 months
- Alcoholic beverages: a desire to drink, but not a strong desire
- Other: never tried other drugs

For answers to question #4, use the following information about whether use of these drugs have led to health, social, legal, or financial problems in the last 3 months:

- Tobacco products: out of breath once or twice after exercising
- Opioids: never tried opioids

[1] WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

- Cannabis: never
- Cocaine: never tried coke
- Amphetamine-type stimulants: ran out of money twice because of buying speed; couldn't pay bills
- Inhalants: never
- Sedatives: haven't used in the last 3 months
- Alcoholic beverages: bad hangovers once every two weeks
- Other: never tried other drugs

For answers to question #5, use the following information about failure to do what was normally expected because of substance use:

- Tobacco products: never
- Opioids: never tried opioids
- Cannabis: never
- Cocaine: never tried coke
- Amphetamine-type stimulants: never
- Inhalants: never
- Sedatives: haven't used in the last 3 months
- Alcoholic beverages: never
- Other: never tried other drugs

For answers to question #6, use the following information about whether a friend or relative has *ever* expressed concern about client's substance use:

- Tobacco products: yes, doctor advised to stop smoking
- Opioids: never tried opioids
- Cannabis: never
- Cocaine: never tried coke
- Amphetamine-type stimulants: yes, boyfriend expressed concern about a month ago
- Inhalants: never
- Sedatives: yes, but not in the last 3 months
- Alcoholic beverages: yes, but not in the last 3 months
- Other: never tried other drugs

For answers to question #7, use the following information about whether client has tried to cut down on using but failed:

- Tobacco products: yes, tried in the last 3 months, but not successful
- Opioids: never tried opioids
- Cannabis: never tried
- Cocaine: never tried coke
- Amphetamine-type stimulants: never tried
- Inhalants: never tried
- Sedatives: used Valium in the past and had to cut down; was successful the first time
- Alcoholic beverages: never tried
- Other: never tried other drugs

For answer to question #8: client has never used drugs by injection.

Resource Page 3.5: ASSIST Role-Play Case Study #2: Abdullah[1]

Abdullah is a client being interviewed using the ASSIST. To answer questions 1 and 2, use the following information about substance use in the last 3 months:

- Tobacco products: every day
- Opioids: use to be addicted to heroin and made several attempts to cut down, but stopped using completely about 3 years ago; therefore, none in the last 3 months
- Cannabis: every day
- Cocaine: never tried
- Amphetamine-type stimulants: not in the last 3 months
- Inhalants: never tried
- Sedatives: never tried
- Hallucinogens: had a couple of trips in the last 3 months
- Alcoholic beverages: once or twice
- Other: had tried kava once years ago and hasn't used since

For answers to question #3, use the following information about strong desire to use in the last 3 months:

- Tobacco products: every day
- Opioids: haven't used in the last 3 months
- Cannabis: every day
- Cocaine: never tried coke
- Amphetamine-type stimulants: haven't used in the last 3 months
- Inhalants: never tried inhalants
- Sedatives: never tried sedatives
- Hallucinogens: never
- Alcoholic beverages: never
- Other: haven't used in the last 3 months

[1] WHO. (2010). *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test.* Geneva: WHO Press.

For answers to question #4, use the following information about whether use of these drugs has led to health, social, legal, or financial problems in the last 3 months:

- Tobacco products: wakes up with a really bad cough once or twice a week for the last 2 years
- Opioids: haven't used in the last 3 months
- Cannabis: last month police gave him a caution for possessing marijuana, but nothing else
- Cocaine: never tried coke
- Amphetamine-type stimulants: haven't used in the last 3 months
- Inhalants: never tried inhalants
- Sedatives: never tried sedatives
- Hallucinogens: never
- Alcoholic beverages: never
- Other: haven't used in the last 3 months

For answers to question #5, use the following information about failure to do what was normally expected because of substance use:

- Tobacco products: never
- Opioids: haven't used in the last 3 months
- Cannabis: 2 months ago forgot to attend an important family event because of smoking marijuana all day. His family got very angry at him because of this
- Cocaine: never tried coke
- Amphetamine-type stimulants: haven't used in the last 3 months
- Inhalants: never tried inhalants
- Sedatives: never tried sedatives
- Hallucinogens: never
- Alcoholic beverages: never
- Other: haven't used in the last 3 months

For answers to question #6, use the following information about whether a friend or relative has ever expressed concern about client's substance use:

- Tobacco products: yes, but not in the last 3 months

- Opioids: yes, but it was years ago
- Cannabis: yes, about 6 months ago
- Cocaine: never tried coke
- Amphetamine-type stimulants: never
- Inhalants: never tried inhalants
- Sedatives: never tried sedatives
- Hallucinogens: never
- Alcoholic beverages: never
- Other: never

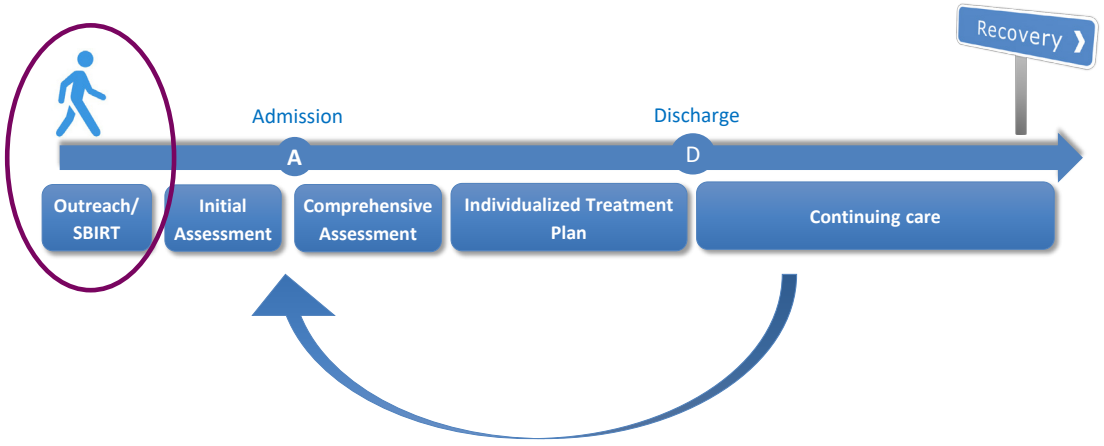
For answers to question #7, use the following information about whether client has tried to cut down on using but failed:

- Tobacco products: yes, tried last month but failed
- Opioids: yes, but not in the last 3 months
- Cannabis: never tried to stop
- Cocaine: never tried coke
- Amphetamine-type stimulants: never been a problem
- Inhalants: never tried inhalants
- Sedatives: never tried sedatives
- Hallucinogens: never had to
- Alcoholic beverages: never had to
- Other: only used once, so never

For answer to question #8: client has used drugs by injection, but not in the last 3 months.

Module 3 - Intake, Screening, and Brief Intervention Summary

Care Pathway



- The care pathway represents the path that a person takes in their recovery process, in this path they participate or access different types of services and/or interventions, which can be offered both by a network of devices and by a single device.
- The diagram identifies a first moment called Outreach/SBIRT, which constitutes the first contact of the person with the system, interventions are carried out aimed at contacting and detecting early and timely people with substance use, (orientation and delivery of information). Screening is also carried out to measure the level of risk of substance use and the first interventions aimed at motivating, engaging and promoting access to appropriate interventions are carried out. These interventions are carried out in community spaces, schools, courts, primary health care, among others.
- The variability of these interventions is given by various reasons, organization of the service networks, resources and diversity of services available, previous treatments of the person (knowledge of the user in the service network), among others.

[8]International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing World Health Organization and United Nations Office on Drugs and Crime, 2020
[9]International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing World Health Organization and United Nations Office on Drugs and Crime, 2020

Outreach/SBIRT

- The aim of outreach is to minimize the time between the onset of the disorder and the initiation of treatment, thereby reducing the negative health and social effects of substance use.
- SBIRT known as Screening brief intervention and referral to treatment is an evidence-based approach to identifying people who use alcohol and other substances at risky levels.
- The goal of SBIRT is to reduce and prevent related health consequences, disease, accidents and injuries. Risky substance use is a health issue that often goes undetected, by incorporating this evidence-based tool that are demonstrated to be valid and reliable in identifying individuals with problem use or at risk for a substance use disorder (SUD) must be used.
- SBIRT can be performed in a variety of settings. Screening does not have to be performed by a physician. SBIRT incorporates screening for all types of substance use with brief, tailored feedback and advice. Simple feedback on risky behavior can be one of the most important influences on changing patient behavior.

Screening process[10]

- Screening is a process that identifies people at risk for the "disease" or disorder. As such screening, refers to a brief procedure used to determine the probability of the presence of a problem, substantiate that there is a reason for concern, or identify the need for further evaluation.
- The screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether or not further assessment is warranted.
- Screening provides an opportunity to initiate discussions with individuals about their substance use. It may be informal or, as we will see later, it may involve the use of a specific screening tool.
- It generally involves the use of standardized procedures for identifying risk factors that may indicate the need for referral. This helps identify the level at which a service should begin.
- Screening provides an opportunity to initiate discussions with individuals about their substance use. It may be informal or, as we will see later, it may involve the use of a specific screening tool.
- It generally involves the use of standardized procedures for identifying risk factors that may indicate the need for referral. This helps identify the level that a service should begin.
- During the screening process, staff members use instruments that are limited in focus, simple in format, quick to administer, and usually able to be administered by non-professional staff.

- Every time you conduct an intake interview and refer the case to a specific service area for assessment, you have performed a type of screening. You have sifted through the intake information and made a brief assessment that suggests if the client should be seen by someone for treatment placement. Documenting your findings in a structured way, using the Intake tool adds consistency while still leaving you room to be flexible in your approach. Many of the people who come into or call to talk to see you will not become ongoing clients. They may be looking for services that are provided by another agency and you may make a referral, or they may be looking for short-term help for a crisis situation and will receive help in a single interaction. For these cases, the Intake tool is important because it represents all or most of the documentation the agency collects about these visits. If the client returns, it is useful to have a record of previous visits. Aside from giving you a starting point for the interview, information about past visits will help you spot underlying chronic problems that may be generating periodic emergencies or crises.
- The options arising from the results of screening should be limited to the following:
  - The individual is likely to benefit from a referral for a comprehensive assessment,
  - More assessment is not warranted at this time, or
  - The screening will be repeated at a later time.
- Screening provides opportunity for education, early intervention.
- It also offers opportunity to engage client further.
- Screening has proved beneficial in reducing high-risk activities for people who do not have a diagnosed substance use disorder.
- Screening usually identifies individuals as having
  - No or low risk of a SUD
  - Moderate risk of a SUD; or
  - High risk of SUD.
- It also identifies the level of care required:
  - Individuals who screen as having no or low risk of a SUD can be congratulated and encouraged to maintain the status quo. They can benefit from substance use abuse prevention sessions for information to increase their awareness of substance use and its consequences.

[11]NCETA as cited Treatnet. (2008). Screening, assessment and treatment planning. http://www.unodc.org/ddt-training/ treatment/a.html

- If there is a history of substance use problems in their family (mother, father, uncle, aunt, grandparent), then information about the genetic components of addiction should be provided. This educational component can be designed to inform clients of effects of SUD's and physical and psychological impacts. They can last from 1 hour to 2 days depending on the client's ability to attend.
    - Those found to be at moderate risk may need only a brief intervention which can last up to 8 weeks.
    - Those found to be at high risk should be referred for further assessment and treatment.
    - We will discuss a brief intervention later in the module.
    - **Note:** All clients who are determined at moderate or high risk should be formally assessed.
    - When conducting a screening:
        - Use a non-judgmental, respectful approach
        - Do not use stigmatizing language
        - Embed screening questions in larger assessment of health habits.

Validity of Screening Instruments

- In curriculum 2, we have mentioned that screening should be conducted using a validated brief instrument (i.e., test) to quickly identify a person's pattern of substance use. The validity of a screening instrument is the degree to which it actually measures what it claims to measure.
- In the past, screening instruments were used to identify active cases of drug dependence, but in recent years, screening has expanded to identify individuals across the full spectrum of use- from risky substance use to addiction.
- The World Health Organization (WHO) has developed two screening instruments that have been tested and validated with international populations:
- AUDIT is a 10-item screening tool developed to identify individuals whose alcohol consumption has become hazardous or harmful to their health.
- The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), developed by an international group of SUD researchers for the WHO, identifies substance use and related problems in primary and general medical care settings.

[12]World Health Organization. (2010). ASSIST-The Alcohol, Smoking and Substance Involvement Screening Test. Geneva: WHO Press.

ASSIST - Administering and coding the ASSIST

- ASSIST, as mentioned, is a validated screening instrument developed by the World Health Organization (WHO). The ASSIST:
  - Contains 8 questions on alcohol, tobacco, and illicit substances (including injection substance use);
  - Gives information on hazardous, harmful, or dependent use
  - Developed for primary care
  - Interview only
  - Studied cross-culturally in 8 countries
- Note that the ASSIST was published in 2010 and has not been updated in language from ICD 10 to ICD 11.
- There are 2 other types of ASSIST especially for children – ASSIST Y – 10- to 14-year-olds and then the ASSIST Y for 15–17-year-olds.
- In general, ASSIST provides information about:
    - Uses an empathic and respectful approach;
    - Incorporates a readiness-to-change model; and
    - Includes feedback and advice.
    - Risk of current or future harm
    - Dependence
    - Injecting substance use
  - To administer the ASSIST Screening test, the professional needs to have three different documents on hand:

1. ASSIST Screening Test Print Form,
2. Patient Response Cards,
3. Patient Feedback Report Card

- These documents are found on Resource pages 3.1 and 3.2. Please turn to those pages so you can see each part in detail.
- Each of these components is described in more detail in the following slides and their role in the process.

[13]WHO. (2010). ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test. Geneva: WHO Press.

Patient Response Cards[13]

- The patient Response Cards include a card called Response Card - Substances:
    - This first card provides a list of common (local) names for different psychoactive substances (Resource page 3.2, Appendix B that is Response Card #1)
    - This allows people being screened to have answer options

Response Card #1 (Substance list)

- After the introductory script is read, the counselor gives the client response card #1 shown on this slide (Resource page 3.2, see the section entitled "Appendix B Assist 3.1 response card for clients"). The card is given to the client before question #1 is asked and is used as a reference for the client while he or she answers the first seven questions. It contains a list of the substance categories the ASSIST covers, and a range of names associated with each category. It is important to ensure that the client is familiar with the substance names on the card. It is possible to amend the list to include local street names for various substances.

Response Card #2 (Frequency of Use)

- Please refer to ASSIST Response card#2 (Resource page 3.2, see section entitled "Appendix B ASSIST 3.1 response card for clients"). This is frequency responses card is given to the client before asking question #2 (and is a reference for the client while answering questions #2 through #5).
- Be sure to review the meaning of each response category, as this is one of the places where errors can occur. For example, the category monthly means that the substance was used a total of 3-9 times in total over the last 3 months. If the client reports use in only 1 or 2 of the past 3 months, one must average the total times used over 3 months. For example, if a client says he used 3 times, but all in one month's time, the average would be 1 time per month in the past 3 months (or "monthly"). If a client used 3-4 times a week, but only for one month, the total number of times would be 12-16 and the answer would be "weekly."
- At this point, the counselor also gives the client a calendar (Resource Page 3.3 to orient the client to the preceding 3 months).

Response Card #3 (Frequency of Use)

- This slide shows ASSIST response card #3 (Resource page 3.2, see section entitled "Appendix B ASSIST 3.1 response card for clients"). This is given to the client before asking question #6 (and is a reference for the client while answering questions #6 through #8).

ASSIST Screening Test Form

1. Use (throughout life) Recent (last three months)
2. Use
3. Strong desire to consume
4. Problems (health, social, legal, economic) caused by the substance
5. Neglect responsibilities Ever
6. Third party concern
7. Attempts to reduce or stop use
8. Intravenous use[14]

How to administer the ASSIST Questionnaire

Response Card #2 (Frequency of Use)

Given to the client and used for questions 2–5

Never: not used in the last 3 months.

Once or twice: 1 or 2 times in the last 3 months.

Monthly: 1 to 3 times in one month.

Weekly: 1 to 4 times per week.

Daily or almost daily: 5 to 7 times per week.

- It is important to see an overview of the ASSIST administration
- This figure above shows a diagram that summarizes the administering of the ASSIST screening test.
- Questions 1 and 2 are filter questions and help determine which psychoactive substances will be investigated in subsequent questions.
- Questions 3, 4, and 5 address CURRENT substance use and its relationship to some health or social problems.
- Finally, questions 6, 7 and 8 seek to establish if someone close to the patient has shown concern about substance use, if the patient has tried to modify substance use and if they have used substances intravenously.

[14]PAHO-WHO. (2013) "ASSIST Screening Test Components" (slide 25)

- The administering of the ASSIST screening test must conclude with the scoring, feedback and Brief Intervention according to the results obtained. These topics are covered in the following sections.

ASSIST Test administering protocol

- Many professionals wonder what the best way is to indicate to the patient the need to explore their substance use. To facilitate this process, it is very important that the professional is empathetic from the first contact with the patient and adopts the style of the motivational interview. It includes five easy-to-use principles: 1) express empathy, 2) create disagreement, 3) avoid arguing, 4) turn around resistance, and 5) encourage self- efficacy. These steps will be discussed in more detail in the next module.

- It is recommended that the professional introduces himself or herself, indicates the objective of the screening test to the patient, briefly describes it and indicates the approximate time of the administering of the test. It is also important that you ensure the confidentiality of the responses and obtain their consent to proceed before conducting the screening. It is important to obtain consent at each step of the process from screening to assessment and for treatment, once the recommended treatment options are known based upon the screening and assessment results.

- Introduce yourself to the user of the service to whom you will apply the screening test, stating your name and position within the institution, for example:

  "Good morning. I am …. social worker at the health center ... we have some questions related to your health and lifestyle that we would like to ask you as part of your consultation ... "

- Mention the purpose of the ASSIST screening test. You can tell the patient:

  "The objective of this test is to identify if the use of some psychoactive substances may be interfering with or could cause damage to your health in the future"

- Briefly describe the screening test to the patient. This is a way to breakdown barriers or resistance that the person may have and clarify what the test is about, for example:

  "I have some general questions and then a test of 8 questions which will ask about the use of different psychoactive substances and some problems that may be related to their use ... It will take approximately 15 minutes to answer all the questions."

- Keep in mind that the consumption of psychoactive substances by some patients may be prohibited by law, their culture or religion. In these cases, it may be necessary to recognize that prohibition and encourage the patient to respond honestly, highlight the confidential nature of the information such as in the following example:

  "Since it is also necessary to know if you have used illegal drugs, it is important that you know that all the information you provide me is strictly confidential."

- It is critically important that you let the person know about any limits of confidentiality. For example, if such information could be accesses by the authorities or any other

powerful entity, this needs to be shared transparently with the person before they share any substance information.

- Once the patient agrees to respond to the screening test, then explain what type of psychoactive substance will be explored and the period of time to which it will refer. As in the following example: "I will ask you questions about your use of alcohol, tobacco, and other drugs throughout life and in the past three months."

- It is also important to give instructions so that patients can respond appropriately. This is the ideal time to provide the support sheet with the list of psychoactive substances and common names, as well as response options, for example:

  "This card can help you to identify the different names that are sometimes used to refer to the substances about which I am going to ask you. For example, in the case of marijuana, you may know it as "pot" or "weed". The second part of the card can help you answer each of the questions by showing you different answer options. Just choose the option that is closest to your current situation".

- During the introduction and when providing instructions for taking the ASSIST screening test, it is important for the healthcare professional to clarify which types of psychoactive substances are relevant to the interview and to ensure that they are referring to them using names that are familiar to the patient. One way to do this is:

  "Some of the substances that we discuss may have been prescribed by a doctor; for this interview we will not record the medications you use by prescription. However, if you have used these medications for reasons other than what the doctor indicated or have taken them with more frequency or in higher doses, please tell me".

- These are some strategies that health professionals can implement during the ASSIST, such as those listed below:

  - Hold the ASSIST so the client cannot see what you type; otherwise, their response may be influenced.

  - Record the answers about each psychoactive substance, including all zeros or negative answers, otherwise it is easy to get confused and get a wrong score.

  - Reframe some questions so that the client understands them and provide examples of the kind of answers you are looking for.

  - Make a picture in your mind of the client's substance use as you answer each subsequent question, this way you can guide the administration of the test and provide the patient with examples consistent with their use pattern.

  - Responses that do not seem consistent with their frequency and pattern of psychoactive substance use should be further investigated to ensure that the questions are adequately explained and understood by the client.

  - Do not forget to use the style of the motivational interview to ask the questions, for example:" Previously you told me that you had never tried amphetamines, however, in this question you tell me that you were fired from your job because

they detected this substance in an anti-doping urine screen. Could you tell me more about this? "

Question 1: Lifetime Use

- We will now look at each question of the ASSIST. Please look at Resource page 3.1 and 3.2 for all materials needed. You will find the ASSIST in Appendix A of Resource Page 3.2
- The first ASSIST question assesses lifetime use as follows:
    - "In your life, which of the following substances (read from response card #1) have you ever used? (non-medical use only)." After asking question #1, the counselor:
    - Documents a yes or no answer;
    - Inquire about all substances;
    - Records any use (even if only tried once);
    - Probes further when needed, such as asking, "Not even at a party?" and
    - Ends the interview if a "No" is given for all substances.
- Note that question #1 is a filter question, meaning that the answer determines what happens next regarding questions posed for specific substances used.
- If the client answers "no" to every substance, the interviewer should ask a probing question such as, "Not even when you were in school?" If the response is still "No" to all the substances, the interview should be stopped. If the client answers "Yes" to question #1 for any of the substances listed, then move on to question #2, which is the first of four questions that ask about substance use in the previous 3 months.

Question 2: Recent Use

- **The second ASSIST question assesses frequency of use during the last 3 months of substances identified as responses to question #1. Note that question #2 is also a filter question in that the answers determine whether the next three questions** (#3, #4, and #5) will be asked. Question #2 is asked as follows:
- "During the past 3 months, how often have you used the substances you mentioned (first substance, second substance, etc.)?" The answers to question #2 are:
    - Never (0)
    - Once or twice (2)
    - Monthly (3)
    - Weekly (4); or
    - Daily or almost daily (6)
- If the client answers "never" to all items in question #2, skip questions #3 to #5 and

move on to question #6. Questions #2 through #5 are scored using the values noted here (0–6). Explain to the client that question #2 should be asked for each of the substances ever used. If any substances have been used in the past 3 months, continue with questions #3, #4, and #5 (next slides) for each substance used.

Question 3: Strong Urge to Use

- The third ASSIST question assesses frequency of experiencing a strong desire or urge to use during the past 3 months.
- "During the past 3 months, how often have you had a strong desire or urge to use (first substance, second substance, etc.)?" The answers to question #3 are noted as:
    - Never (0);
    - Once or twice (2);
    - Monthly (3);
    - Weekly (4); or
    - Daily or almost daily (6).
- Question #3 reflects high-risk use of or dependence on a substance. A high score on this question is usually associated with high-risk dependent use rather than hazardous risky use. For example, if the person is a daily smoker, he or she is likely to be experiencing these cravings daily. In this case, cigarette cravings can be an example when you ask about cravings for other substances. You could ask, "You know the level of craving that you get for a cigarette; how often have you experienced that level of craving for alcohol, for cannabis etc.?"

Question 4: Health, Social, Legal, or Financial Problems

- The fourth ASSIST question assesses the frequency of experiencing health, social, legal, or financial problems related to substance use in the previous 3 months.
- "During the past 3 months, how often has your use of (first substance, second substance, etc.) led to health, social, legal, or financial problems?" The answers to question #4 are:
    - Never (0);
    - Once or twice (4);
    - Monthly (5);
    - Weekly (6); or
    - Daily or almost daily (7).

- Many clients may not be aware of problems caused by their substance use, most notably, health problems, and this may be the first opportunity to help the client link substance use and problems. To help the client answer this question, give the client response card #3 (Resource Page 3.7, page 129 in your manuals) before asking question #4 (used as a reference with examples of health, social, legal, and financial problems). (The client will return ASSIST response card #3 to the counselor after the completion of question #4).
- It is important to provide examples of the kinds of problems that are associated with each substance. Alcohol, for example, can lead to bad hangovers, gastrointestinal problems, or doing things when drunk that are later regretted. For amphetamines, ask about a bad come-down when the person felt depressed, anxious, and irritable. For cocaine, ask about irrational thoughts, anxiety, and feeling angry and irritable. Asking such questions helps the client understand what you mean; for some clients, it could be the first time they realize that their use is causing them problems.

Difficulties/Problems Related to Hazardous, Harmful and Dependent Substance Use

The kinds of problems related to harmful regular use and dependence develop over a period of time and may include:

- specific physical and mental health problems,
  - decreased immunity to infection,
  - anxiety and depression,
  - sleep problems,
- withdrawal symptoms when use is reduced or stopped,
- financial difficulties,
- legal problems,
- relationship problems,
- work problems.

Question 5: Failure to Fulfill Major Role Responsibilities

- **Before asking question #5, give the client response card "Frequency responses" in Appendix B.**
- The fifth ASSIST question assesses failure to fulfill major role responsibilities:
- "During the past 3 months, how often have you failed to do what was normally

expected of you because of your use of (first substance, second substance, etc.)?"1 The answers to question #5 are:

- Never (0);
- Once or twice (5);
- Monthly (6);
- Weekly (7); or
- Daily or almost daily (8).

- Some clients who are dependent on a substance may no longer have role responsibility because they may have lost their family, job, or home as a result of their substance use. When this is the case, rather than score "never," use as prompts such things as house cleaning, feeding themselves, or keeping appointments with doctors.
- Note that question #5 does not ask about tobacco use because it is unlikely such use would cause failure to fulfill role obligations. It is important to give the client examples of what failing to fulfill role obligations means, such as missing work and getting into trouble with the boss, losing pay, failing to look after children properly, or failing to maintain a relationship with a partner.

Question 6: External Concern

- The sixth ASSIST question is meant to find out whether another person (e.g., family member, friend, partner, spouse, parents, children, doctor, employer, teacher) has expressed concern over the client's substance use.
- "Has a friend or relative or anyone else ever expressed concern about your use of (first substance, second substance, etc.)?"1 The answers to question #6 are:
  - No, never (0);
  - Yes, in the past 3 months (6); or
  - Yes, but not in the past 3 months (3).
- Reminder: Use the response card that relates to ASSIST questions 6-8 found in resource page 3.2 Appendix B.
- Note that all substances that were recorded when the client responded to the first question on lifetime use must be inquired about in this question (not just those substances used in the past 3 months).

Question 7: Failed Attempts to Control Substance Use

- **The seventh ASSIST question inquires about failed attempts to control one's use of a substance.**
- "Have you ever tried and failed to control, cut down, or stop using (first substance, second substance, etc.)?"1 The answers to question #7 are:

- No, never (0);
- Yes, in the past 3 months (6); or
- Yes, but not in the past 3 months (3).
- Question #7 is an indicator of dependence or high-risk use because it helps determine whether loss of control over substance use has been experienced during the client's lifetime. However, question #7 tends to be the most confusing. It is helpful to ask the question like this: "Have you ever tried to cut down on drinking alcohol, but failed?" Clients can score zero on this question for three reasons:
- They have never tried to cut down because it is not an issue (e.g., they have tried methamphetamine only once, or they drink alcohol in moderation).
- They have never tried to cut down because, even though they may be using in a risky way, they don't see any problem with their use.
- They have tried to cut down, and they were successful in that attempt. If they were successful the first time they tried to cut down, they score 0. If they made several attempts to cut down and were eventually successful, then it's necessary to find out when the last time was that they tried and failed, and record that.
- As when the counselor was scoring question #6, all substances that were recorded when asked the first question on lifetime use must be inquired about in this question (not just those substances used in the past 3 months).

Question 8: Injecting Substance Use

- **The eighth ASSIST question inquires about the client's injection substance use.**
- "Have you ever used any substance by injection (non-medical use only)?"1 The answers to question #8 are:
  - No, never (0);
  - Yes, in the past 3 months (2); or
  - Yes, but not in the past 3 months (1).
- If the client answers yes, the counselor must query about the pattern of injecting, as explained on the next two slides.
- Injection is treated separately because it is a particularly high-risk activity associated with increased risk of dependence, blood-borne viruses such as HIV and hepatitis C, and other substance-related problems.
- Although the response to question #8 does not contribute to the final substance scores injecting substance use is an indicator that the client may require further assessment and referral for treatment. If the client has injected substances in the past 3 months:[1]
  - Review the "risks associated with injecting" card with the client, including procedures around safer injecting (Resource Page 3.2, See QUESTION 8 and note about injection);

- Recommend client be tested for HIV and hepatitis B and C; and
- Determine the frequency and pattern of injecting in the past 3 months to determine whether a referral is warranted (as a general rule, clients injecting an average of more than four times per month may require a referral to specialized treatment).

- In response to a "yes" answer to question #8, the pattern of injecting must be queried as presented on the next slide.

Feedback Report Card

- **All clients screened using ASSIST should also receive a feedback report card**, showing their specific scores for each substance. As the report card indicates, a score is given for each substance listed (including a place for "other" if a substance is not on the list). This feedback report card is found in Resource page 3.2 Appendix C.
- The card also gives an explanation of what "lower," moderate," or "high" scores mean. Note that the report card is included with the blank ASSIST in your manuals.
- Be aware that because of continued stigma and a real risk of arrest in some areas, the counselor may not want to give the client the report card to take with him or her.
- When explaining scores to clients this is a way to reference how they scored. It defines each level and what it means.
- **Lower:** You are at lower risk of health and other problems from your current pattern of use.
- **Moderate:** You are at moderate risk of health and other problems from your current pattern of substance use.
- **High:** You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent.

Provide Brief Description of the Test...

I have some general questions and then a test of 8 questions which will ask about the use of different psychoactive substances and some problems that may be related to their use... It will take approximately 15 minutes to answer all the questions.

Ensure Confidentiality...

"Since it is also necessary to know if you have used illegal drugs, it is important that you know that all the information you provide is strictly confidential"

Scoring the ASSIST

- Not that each question has a set of responses to choose from and each response has a numerical score. The counselor circles the numerical score that corresponds to the client's response for each question. At the end of the interview, the scores for each substance (questions #2 through #7) are added together to produce a substance-specific score (referred to as the "ASSIST risk score" for each substance). The scores are weighted according to frequency of use.
- Above diagram shows the calculation of a client's ASSIST risk score for cannabis (note that the results from question #1 and question #8 are not included in this score).

Specify Time Period and Scope of Substances to Be Explored

"I will ask you questions about your use of alcohol, tobacco, and other drugs throughout your life and in the past three months."

- The ASSIST determines a risk score for each substance. This score can be used to start a discussion (brief intervention) with clients about their substance use:
  - The score for each substance falls into a "lower," "moderate," or "high" risk category; and
  - The risk category determines the most appropriate intervention or referral to assessment and treatment. Be careful! Do not blindly interpret the score. A client

can score in the "Moderate Risk" range because of past use (e.g., answered "Yes, but not in the past 3 months" for questions #6 and #7) but may not be currently using.

- As you discuss the scores and levels of risk, you can also provide information about the substances they use and the minimum level of intervention. The three levels of risk and the appropriate intervention for each are as follows:
- For clients whose ASSIST score indicate that they are at low risk of substance-related harm for all substances, provide feedback and information—there is no need for a brief intervention;
- For clients whose ASSIST score indicates that they are at moderate risk of harm, offer a brief intervention; and
- For clients whose Specific Substance Involvement score is 27 or more for any substance or who have regularly injected substances in the past 3 months and are likely to be at high risk and substance dependent, provide more than just a brief intervention. These clients require further assessment and more intensive treatment.

Common mistakes in scoring the ASSIST include:

- Over-scoring questions #3 and #5. These questions reflect:
  - Dependent use and strong craving (question #3); and
  - Loss of control and failure to fulfill obligations (question #5).
- Forgetting that questions #1 and #2 are filter questions:
  - Question #1 determines which substance categories to ask about in question #2; and
  - Question #2 determines whether to ask questions #3, #4, and #5.
- Including question #1 in scoring. Questions #3 through #7 constitute the substance specific scores (question #1 is not to be included in the scoring).

Brief Intervention

- Brief intervention can be provided through a single session or multiple sessions of motivational interventions. These interventions can be provided by and SUD counselor or peer counselor. They may also be provided by trained medical or social services program staff.
- Effective brief intervention:
  - Uses an empathic and respectful approach;
  - Incorporates the-to-change model; and
  - Includes feedback and advice.
- Brief intervention is a concept that has been successfully in identifying substance use issues early and getting individuals into treatment earlier. It is also important that, as

a first step in the screening process, the counselor gains the client's trust and mutual respect.

- Initially developed for healthcare workers, the concept of brief intervention was a logical next step after a counselor had established a relationship with a client. For counselors in a SUD treatment setting, the following can help provide an effective brief intervention:[1]
  - Engage clients early by using the techniques described in Module 4: using reflective listening, asking permission, and asking open-ended questions.
  - If the client was referred by healthcare workers (e.g., doctors, nurses), get the worker's support.
    - The client may already have established a relationship with a healthcare worker;
    - The client may have received immunizations, blood pressure checks, and warnings about eating, drinking, and smoking habits;
    - The client may be seeing a healthcare worker more frequently because of unhealthy habits; and
    - The client possibly regards the referring healthcare worker as being credible.
- If the client is self-referred, gain his or her trust and explain that the screening is part of a larger intervention process.
- Early recognition of substance-related problems allows interventions to occur before dependence or irreversible damage has developed or before problems become more complex and difficult to treat. However, SUDs can be difficult to detect, especially in the early stages. The rationale for brief intervention includes the following:
  - Substance use problems are widespread worldwide;
  - Substance use problems are associated with significant morbidity and mortality; and
  - Effective early interventions can result in:
    - A connection of substance use to health issues;
    - Identification of problematic substance use;
    - Reduction of substance use; and
    - Admission to treatment.
- There are 5 components to an effective Brief Intervention.
- They are:

1. Introducing the issue in the context of the patient's health
2. Screening and assessing

3. Providing feedback
4. Talking about change and setting goals
5. Summarizing and reaching closure

- The ASSIST is an effective Screening Tool Used in conjunction with a Brief Intervention. It
  - Substantiates there is a reason for concern
  - Provides opportunity for education; early intervention
  - Alerts risks for interactions with medication
  - Offers opportunity to engage client
  - Identifies the need for further evaluation
  - Proven to be beneficial in reducing high-risk activities
- In an International study, the benefits of Screening and Brief Intervention (BI) are listed as
  - ASSIST follow up scores significantly lower than baseline scores
  - Brief intervention was effective compared with no intervention in reducing substance use & risk
  - BI influenced cutting down, stopping use, thinking about stopping, feeling better
  - Study results supported earlier studies that found brief interventions to be cost-effective
  - Opportunity to generate "change talk" with the ASSIST appeared to play a significant role in influencing behavior change

How Is the ASSIST-Linked BI Conducted?

- A specific model of brief intervention is the ASSIST-linked brief intervention, which is for the clients who already were administered the ASSIST;
  - A short intervention: 3 to 15 minutes long;
  - A means of providing personalized feedback;
  - A process of sharing ASSIST risk scores; and non-confrontational.
- The ASSIST-linked brief intervention was specifically designed for people who are at "moderate risk" regarding their substance use, those who are not dependent but are using substances in harmful ways that may contribute to health, social, financial, legal, or occupational problems. However, those who are deemed dependent may get a

brief intervention and should be referred to treatment.

FRAMES framework

- "Clinical experience and research into brief interventions for substance use have found that that effective brief interventions comprise a number of consistent and recurring features. These features have been summarised using the acronym FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy"
- "The features of FRAMES most relevant to a short ASSIST-linked brief intervention include Feedback, Responsibility and Advice. A description of each of these is given below along with examples of using these techniques within the confines of the ASSIST-linked brief intervention".
- Feedback: "is the provision of personally relevant information which is pertinent to the client and is delivered by the health care worker in an objective way. 'Much of the feedback given in an ASSIST-linked brief intervention can be delivered by reading directly from the ASSIST feedback report card"
- Responsibility: "A key principle of intervention with substance users is to acknowledge and accept that they alone are responsible for their own behaviour and will make choices about their substance use and about the course of the brief intervention given by the health worker."
- Advice: "A central component of effective brief interventions is the provision of clear objective advice regarding how to reduce the harms associated with continued use. This needs to be delivered in a non-judgmental manner"
- Menu of alternative change options: "Effective brief interventions and self-help resources provide the client with a range of alternative strategies to cut down or stop their substance use. This allows the client to choose the strategies which are most suitable
- for their situation and which they feel will be most helpful. Providing choices reinforces the sense of personal control and responsibility for making change and can help to strengthen the client's motivation for change".
- Empathy: "An important principle of motivational interviewing is the expression of empathy by the health care worker to the client. In a clinical situation empathy comprises an accepting, non-judgmental approach that tries to understand the client's point of view and avoids the use of labels such as 'alcoholic' or 'drug addict'. It is especially important to avoid confrontation and blaming or criticism of the client. Skillful reflective listening which clarifies and amplifies the person's own experience and meaning is a fundamental part of expressing empathy. The empathy of the health worker is an important contributor to how well the client responds to the intervention"
- Self-efficacy: "The final component of effective brief interventions is to encourage clients' confidence that they are able to make changes in their substance use behaviour. People who believe that they are likely to make changes are much more likely to do so than those who feel powerless or helpless to change their behaviour. It is particularly

helpful to elicit self-efficacy statements from clients as they are likely to believe what they hear themselves say"

- The ASSIST-linked brief intervention follows 10 steps. Here are the first five:

1. Asking clients whether they are interested in seeing their ASSIST scores;
2. Providing personalized feedback using the ASSIST feedback report card;
3. Giving advice about how to reduce risk associated with substance use;
4. Allowing clients to take ultimate responsibility for their choices; and
5. Asking clients how concerned they are about their scores.

- These first five steps are used for a short 3-minute intervention. For a longer brief intervention, there are five additional steps WHO. (2010). Brief intervention: The ASSIST- linked brief intervention for hazardous and harmful substance use. Geneva: WHO Press.

6. Weighing the good things about using the substance;
7. Weighing the less good things about using the substance;
8. Summarizing and reflecting on clients' emphasis on the "less good things";
9. Asking clients how concerned they are by the "less good things"; and
10. Giving clients take-home materials to bolster the brief intervention.

Steps 1 and 2: Ask and Give Feedback

- The ASSIST feedback report card completed at the end of the ASSIST interview is used as the basis for the brief intervention as it provides personalized feedback to the client about his or her level of substance-related risk.
- One way of starting the conversation is to ask the client whether he or she is interested in seeing the results (Step #1 from the previous two slides). However, be aware that, due to stigma and potential legal harm to a client if he or she is known to use substances, you may not want to have the client take the report card with him or her.
- You can ask, "Are you interested in seeing how you scored on the questionnaire that you just completed?" This allows the client to maintain personal control over the situation and reduces client resistance.
- If the client indicates interest in learning how he or she scored, use the report card to provide feedback (Step #2). You can say, "I'd like to share with you the results of the questionnaire you just completed. These are your scores for each substance that we talked about. You scored a 14 for alcohol, which puts you in the moderate risk group for that substance. You scored in the low-risk group for all other substances."
- After giving feedback on the client's scores, the counselor can elicit discussion from the client by asking, "How concerned are you by your score?"

Step 3: Offer Advice

- Step #3 is to offer advice, such as, "The best way to reduce your risk of substance-related harm is to cut back on your use; that is, to move from this moderate-risk category (point to report card) back to the low-risk category (point)." • When appropriate, this is also an opportunity to educate the client about sensible drinking limits, such as the following recommendations by the U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA):
- No more than 14 drinks/week for men (2/day); and
- No more than 7 drinks/week for women and people ages 65 and older (1/day).

Steps 4 and 5: Place Responsibility on the Client and Elicit Client Concern

- **Step #4 is to place responsibility for change on the client by saying, "What you do with the information is up to you.** I am here to assist you if you would like help cutting back on your use."
- **Step #5** is to elicit client **concern:**
  - "What are your thoughts about your scores, particularly the one for alcohol?"
- **Steps #6 and #7 encourage clients to weigh the benefits and costs of at-risk us**e:
  - What are some of the good things about using for you personally?
  - What are some of the less good things?
  - What are some of your concerns about these less good things?

Step 8: Summarize and Reflect on the "Not-So-Good" Things

- **Step #8 is to summarize and reflect on the "less good" things the client is saying and to highlight the discrepancy** between the client's goals and his or her current situation with substance use:
- "OK, so on the one hand, you have mentioned a lot of good things about getting high: you have a great time at parties, you are not so inhibited around your friends, everyone thinks you are the life of the party. But on the other hand, you have missed a lot of class time, your grades are suffering, and school is very important to you."

Step 9: Ask How Concerned Client Is About "Not-So-Good" Things

- • Step #9 involves asking clients how concerned they are by the "not-so-good things." This is an open-ended question (like Step #5) regarding concern about their ASSIST score:

- "Do the less good things concern you? Tell me how."

Step 10: Provide Take-Home Materials

- **Step #10 involves giving clients take-home materials (if it is safe to do so) to bolster the brief intervention.** Take-home materials may include:

  1. ASSIST feedback report card;
  2. General information pamphlets on the substance being used;
  3. Self-help strategies for cutting down or stopping substance use; and
  4. Risks-of-injecting card (if relevant).

- Clients who have high scores on the ASSIST (high-risk clients) should receive a referral to specialized treatment in addition to a brief intervention. Be prepared to make referrals for further assessment and treatment:

  - Giving a phone number is not enough;
  - Become familiar with local community resources;
  - Take a proactive role in learning about the availability of appointments or treatment slots, costs, and transportation; and
  - Get names of contact persons at each program.

- It is helpful to have follow-up visits with clients to support their efforts to cut down or stop using. At a follow-up visit:

  - Inquire about use;
  - Review goals and progress;
  - Reinforce and motivate; and
  - Review tips for progress.

MODULE 4

ASSESSMENT

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Training goals and learning objectives 184
PowerPoint slides 185
Resource page 232
Summary 256

Content and Timeline	
Activity	***Time***
Introduction to Module 4	10 minutes
Interactive Presentation: Introduction to Assessment	20 minutes
Large Group Discussion- Domains of Interest?	60 minutes
Lunch	*60 minutes*
Interactive Presentation: Comprehensive Assessment Domains	5 minutes
Interactive Presentation: Comprehensive Assessment Example: Addiction Severity Index (ASI)	45 minutes
Interactive Presentation: Comprehensive Assessment: ASI Domains Medical and Employment	25 minutes
Small Group Exercise– Medical and Employment/Support Questions?	65 minutes
Break	*15 minutes*
Interactive Presentation: Comprehensive Assessment: ASI Domains Drug Use and Alcohol Use	15 minutes
Small Group Exercise– Drug Use and Alcohol Use Questions?	20 minutes
Day 2 Wrap-up	5 minutes
End of Day 2	

Content and Timeline	
Activity	***Time***
Review of Day 2	10 minutes
Interactive Presentation: Comprehensive Assessment: ASI Domains Legal Status and Family/Social Status	20 minutes
Large Group Discussion– Legal and Family/Social Questions?	30 minutes
Interactive Presentation: Comprehensive Assessment: ASI Domains Psychiatric Status and Other Issues	25 minutes
Small Group Exercise- Issues, questions or areas - do you need to add to a comprehensive assessment?	35 minutes
Break	*15 minutes*

Module 4 Goals and Objectives

Training goals

- Provide an overview of the evaluation process;
- Familiarize the participants with the central elements of the initial evaluation; and,
- Give participants an introduction to the domains of comprehensive assessment in substance use disorder treatment.

Learning objectives

Participants who complete Module 4 will be able to:

- Describe the key elements of the assessment process;
- Describe the process of the initial assessment;
- Describe the process of a comprehensive assessment;
- List the 4 main domains of assessment; and,
- Identify assessment instruments for the different life areas / problems.

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Treatment of Substance Use Disorders
The Universal Treatment Curriculum for Substance Use Disorders (UTC)
UTC 5
Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals
MODULE 4—ASSESSMENT
THE COLOMBO PLAN
DAP
Drug Advisory Programme

Module 4 Learning Objectives

- Describe the key elements of the assessment process
- Describe the process of the initial assessment
- Describe the process of a comprehensive assessment
- List the main domains of assessment
- Identify assessment instruments for the different life areas/problems

4.2

What Do You Know About Assessment?

- What do you already know about assessment of those with a substance use disorder?

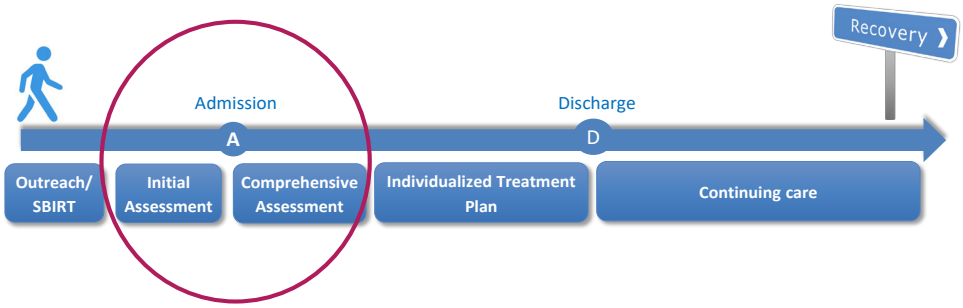
4.3

Screening vs Assessment

- Screening – is a process for evaluating the possible presence of a particular problem
- Assessment – is a process of defining the nature of the problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis

4.4

Care Pathway



Ref:
- Models of Care for Treatment of Adult Drug Misusers (NTA, 2002) NTA Business Plan 2005/06 (NTA, 2005) NTA Treatment Effectiveness Strategy Briefing 2005–08 (online at www.nta.nhs.uk) Treating Drug Misuse Problems: Evidence of Effectiveness (NTA, 2006)
- Doyle J, Ivanovic J (2010) National Drugs Rehabilitation Framework Document. National Drugs Rehabilitation Implementation Committee. Dublin: Health Services Executive

4.5

Four Assessment Competencies (TAP 21)

- Select a process that is sensitive to gender, race, ethnic culture, and disabilities
- Analyze and interpret the data to determine treatment recommendations
- Seek appropriate supervision and consultation
- Document assessment findings and recommendations

Any person performing assessments needs to be able to show these competencies

Source: Center for Substance Abuse Treatment. (2009). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice,* TAP 21, HHS Publication No. (SMA) 08-4171. Rockville, MD: SAMHSA.

4.7

Perform Informed Consent Before Any Service Occurs

Screening, initial assessment, comprehensive assessment, and subsequent treatment activities must be **voluntary**, **based on the patient's informed consent** and their **right to withdraw** from participation at any stage

International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing. Geneva: World Health Organization and United Nations Office on Drugs and Crime; 2020. License: CC BY-NC-SA 3.0 IGO

4.8

Initial Assessment: Purpose

- Identify the most essential information needed to inform which level of care a client needs
  - The initial clinical diagnosis of the substance use disorder according to the ICD-11 criteria
  - Provide a baseline of his/her functioning when entering treatment
- The initial assessment, in turn, feeds into the comprehensive assessment and then informs the treatment plan.

4.9

Initial Assessment

The dimensions to be evaluated at this first stage may vary based on community standards:

1. Substance use
2. Physical and mental health needs
3. Preparedness for behavior change and motivation to enter treatment
4. Recovery atmosphere (family support and social support)

4.10

Initial Assessment Phases

The following phases of the Initial Assessment can be identified:

1. Welcome
2. Evaluation
3. Feedback
4. Referral

4.11

Admission

Once the person is referred to a treatment modality, according to the results of the Initial Evaluation, the next step is to start the admission process to a specific treatment program.

Normally each treatment program will have a written admission policy that establishes the characteristics and procedures that must be carried out.

World Health Organization and United Nations Office on Drugs and Crime, 2020, International standards for the treatment of drug use disorders

4.12

Admission and Informed Consent

It is essential that admission to a treatment program is voluntary, which is guaranteed through a written and signed document, called Informed Consent.

World Health Organization and United Nations Office on Drugs and Crime, 2020, International standards for the treatment of drug use disorders

4.13

Informed Consent

The consent must establish that during the admission the clients received adequate information regarding:

- Documentation of the program, objectives, treatment methods and standards
- Obligations and rights, privacy, non-discrimination and confidentiality
- The role of staff
- Philosophy of the treatment program
- Rules
- Administrative aspects (cost and methods of payment)
- After signing the informed consent, admission to the treatment program is formalized, which begins with the Comprehensive Evaluation process

4.14

World Health Organization and United Nations Office on Drugs and Crime, 2020, International standards for the treatment of drug use disorders

Purpose of Comprehensive Assessment

The purpose of Comprehensive assessment is multi-faceted:

- Determine the extent of the person's need for
  - behavioral health services
  - physical health
  - housing, education and vocational needs

4.15

Purpose of Comprehensive Assessment

- Determines the necessity for the level of care for substance use disorder treatment
- Determines the type of intervention that will be necessary to address the problems
- Evaluates the strengths the client brings to treatment to support recovery
- Engages the client in the treatment process

4.16

Comprehensive Assessment: Process

- A comprehensive assessment must first be completed before treatment begins.
- A shorter follow-up assessment can also be used that
  - asks about recent past in the different assessment domains
  - measures the person's progress and determines need for changes to the treatment plan
- Any assessment must actively involve the person in their own recovery process.

4.17

Large Group Discussion – Domains of Interest?

- What are some of the significant areas of a client's life that a counselor would want to know to do a thorough assessment to determine the level of care and develop an individualized and realistic treatment plan?

4.18

Lunch

60 minutes

4.19

Comprehensive Assessment Domains

Examines the breadth and depth of factors related to substance use disorders and recovery

Should examine at least these domains:

- Physical health
- Mental Health
- Alcohol and drug use
- Legal issues
- Family and social functions
- Employment/support status

Flexible, open and dynamic process

4.20

Comprehensive Assessment Example: Addiction Severity Index (ASI)

The ASI is probably the most widely used standardized instrument used for clinical assessment and research of Substance Use Disorders

In comprehensive assessment, ASI can be used to:

- Assess the problem severity
- Monitor and quantify changes in the problems commonly associated with substance use

4.21

The ASI: Description

- Target population: Adult
- Number of items: 200
- Time of administration: 50 minutes to 1 hour
- Requires training for administration
- Time required to score/interpret: 5 minutes–severity rating
- Norms are available

McLellan, A. T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., Pettinati, H., & Argeriou, M. (1992). The fifth edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment, 9*(3), 199–213.

4.22

The ASI: Description

- Designed to examine the extent of problems in seven domains of life that are often affected in people who have substance use disorders
  - medical status
  - employment and support
  - drug use
  - alcohol use
  - legal status
  - family/social status
  - psychiatric status

4.23

Clinical Utility of the ASI

- A brief semi-structured instrument
- A guide for substance use disorder treatment intake
- A process of collecting information regarding nature and severity of substance use and the related issues in other life domains
- An evaluation tool with clinical, program, and research applicability

4.24

The ASI: Description

3 types of Scores are obtained:

- Patient Rating scale (0-4)
- Interviewer Severity Rating (0-9)
- Confidence Rating (0 or 1)

The initial ASI collects both lifetime history and past month information

The follow-up ASI only asks about past month information to determine change over time

4.25

Reminder of UTC 5 Learning Objectives

- Describe the process of comprehensive assessment
- Identify instruments for measuring the different life areas/problems

This course does not provide training on how to administer the ASI.

4.26

ASI versions

- Teen Addiction Severity Index (T-ASI)
- Addiction Severity Index - Lite version (ASI-Lite)
- Addiction Severity Index – Crime (ASI-C) – asks more detailed information on legal issues
- The WISE Course also provides a more feminized version of the ASI

https://www.emcdda.europa.eu/drugs-library/teen-addiction-severity-index_en
https://adai.uw.edu/instruments/pdf/addiction_severity_index_lite_baseline_followup_5.pdf
https://www.emcdda.europa.eu/drugs-library/addiction-severity-index-lite_sk
https://www.drugsandalcohol.ie/26815/1/Addicition%20Severity%20Index%20-%20crime.pdf

4.27

Teen Addiction Severity Index (T-ASI)

- Population: Adolescents
- Domains measured / Life Areas / Problems Assessed:

Chemical use
School status
Employment/support
Family relationships
Peer/social relationships
Legal status (involvement with criminal justice program)
Psychiatric status
Contact list for additional information

- Administration Time: 30 - 45 minutes

https://www.emcdda.europa.eu/html.cfm/index4004EN.html

4.28

Addiction Severity Index - Crime

- Population: Clients within different sectors of care, for example: prison and probation
- A supplement to the ASI to find out more about legal issues
- Administration Time: Interview 20-30 minutes

https://www.emcdda.europa.eu/html.cfm/index3572EN.html

4.29

Addiction Severity Index - Lite

- The Addiction Severity Index - Lite version (ASI-Lite) is a shortened version of the Addiction Severity Index (ASI).
- The ASI-Lite contains fewer questions than the original versions of the ASI, and omits items relating to severity ratings, and a family history grid.
- Administration Time: 30 minutes

https://datashare.nida.nih.gov/instrument/addiction-severity-index-lite

4.30

Addiction Severity Index: Flexibility

- The ASI was designed to capture the minimum information necessary
- The ASI developers encourage the addition of focused questions and/or additional instruments in the course of evaluating patients to capture a complete picture of needs to inform the treatment plan.

4.31

Comprehensive Assessment: ASI Domains

4.32

Comprehensive Assessment: ASI Domains

Medical status

4.33

ASI Medical Section

To gather basic information about:

- Client's medical history
- Lifetime hospitalizations
- Long-term medical problems
- Recent physical ailments

4.34

Optional Questions to be Added
M12: Hepatitis

M12. Have you ever been tested for hepatitis? ☐
0 = No, 1 = Yes

M12a. If Yes, what was the result? ☐
1 = Hep Negative (not infected)
2 = Hep positive (infected)
3 = Don't Know
• If M12 = No, M12a = "N"

M12b. Would you like help obtaining a Hepatitis test? ☐

4.35

Optional Questions to be Added
M13: HIV/AIDS

M13. Have you ever been tested for HIV? ☐
0 = No, 1 = Yes

M12a. If Yes, what was the result? ☐
1 = HIV Negative (not infected)
2 = HIV positive (infected)
3 = Don't Know
• If M13 = No, M13a = "N"

M13b. Would you like help obtaining an HIV test? ☐

4.36

Optional Questions to be Added
M14: Pregnancy

If patient is Male, code all "N" 0=No, 1=Yes, 2=Unsure

M14. Are you currently pregnant? ☐

M14a. If pregnant; do you have prenatal care? ☐

M14b. If unsure; would you like help obtaining a pregnancy test? ☐

- If M14= 0 or 2 (No or Unsure), M14a = N
- If M14= 1 (Yes), M14b = N

4.37

Other Instruments For Medical Status

the 20-Item Short Form Survey (SF-20): Has six questions to address physical functioning and is in the public domain

2. For how long (if at all) has your **health limited you** in **each** of the following activities?

	Limited for more than 3 months	Limited for 3 months or less	Not limited at all
a. The kinds or amounts of **vigorous** activities you can do, like lifting heavy objects, running or participating in strenuous sports	○ 1	○ 2	○ 3
b. The kinds or amounts of **moderate** activities you can do, like moving a table, carrying groceries, or bowling	○ 1	○ 2	○ 3
c. Walking uphill or climbing a few flights of stairs	○ 1	○ 2	○ 3
d. Bending, lifting, or stooping	○ 1	○ 2	○ 3
e. Walking one block	○ 1	○ 2	○ 3
f. Eating, dressing, bathing, or using the toilet	○ 1	○ 2	○ 3

https://www.rand.org/health-care/surveys_tools/mos/20-item-short-form.html

4.38

Comprehensive Assessment: ASI Domains

Employment/ support

4.39

ASI Employment /Support Section

To gather basic information about:

- **Resources a client can record on a job application**
- **Schooling/training**
- **Current sources and amounts of income**

4.40

ASI Employment /Support Section International Optional Question To Be Added

E4a. Are your job options limited by lack of transportation?

0 = No 1 = Yes ☐

Consider adding a question:

What other individual, family or social issues limit your job options (Write answer in blank)?

_____

4.41

ASI Employment /Support Section
E7 Codes: ISC0 Categories

International Standard Classification of Occupations

1. Legislators, officials
2. Professionals
3. Technicians / assoc. professionals
4. Clerks
5. Service & sales
6. Skilled agricultural / fish
7. Craft & trades
8. Plant / machine operators
9. Elementary occupations
0. Armed forces

4.42

Small Group Exercise– Medical and Employment/Support Questions?

- What are the missing issues and questions to be added for the medical and employment/support domains of the ASI?

4.43

Break

15 minutes

4.44

Comprehensive Assessment: ASI Domains

Drug use

4.45

List of Commonly Used Drugs

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor, grain (methyl alcohol)
Heroin:	Smack, H, Horse, Brown Sugar
Methadone:	Dolophine, LAAM
Opiates:	Opium, Fentanyl, Buprenorphine, pain killers Morphine, Dilaudid, Demerol, Percocet, Darvon, etc.
Barbiturates:	Nembutal, Seconal, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinal, Doriden, etc.
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate, Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine, Crack, Rock, etc.
Amphetamines/: Stimulants	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal, Khat
Cannabis:	Marijuana, Hashish, Pot, Bango Igbo, Indian Hemp, Bhang, Charas, Ganja, Mota, Anasha
Hallucinogens:	LSD (Acid), Mescaline, Psilocybin (Mushrooms), Peyote, PCP, MDMA, Ecstasy, Angel Dust
Inhalants:	Nitrous Oxide (Whippits), Amyl Nitrite (Poppers), Glue, Solvents, Gasoline, Toluene, Etc.

Treatnet International List of Commonly Used Drugs

4.46

ASI Drug Section Optional Question To Be Added D36: Quit without treatment?

D36. How many times have you tried to quit using substances without treatment? ☐☐

4.47

ASI Drug Section Optional Question To Be Added D37: Nicotine

D37. Nicotine

	Lifetime (years)	Past 30 Days	Route of Admin

4.48

ASI Drug Section Optional Question To Be Added D39a-e: Motivation questions

D39. Using the patient rating scale, how would you rate your level of agreement with the following statements?

a. I am ready to decrease my drinking. ☐

b. I am ready to decrease my drug use. ☐

c. I believe I can manage my alcohol use. ☐

d. I believe I can manage my drug use. ☐

e. I know I have a drinking or drug problem and I am motivated to work on it! ☐

4.49

Comprehensive Assessment: ASI Domains

Alcohol use

4.50

If Alcohol Use is Common- Additional Measure May Be Helpful Assessment Tools

Short Alcohol Dependence Data Questionnaire (SADD)

- suitable for patients seeking help with a drinking problem
- measures present state dependence
- sensitive across the full range of dependence
- (sensitive to change over time
- relatively free of sociocultural influence- translated into multiple language and no charge for use

Raistrick DS ; Dunbar G ; Davidson RJ. Development of a questionnaire to measure alcohol dependence. British Journal of Addiction 1983;78:89-95.

4.51

Small Group Exercise– Drug Use and Alcohol Use Questions?

Discuss

1. What substances need to be added
2. What order of administration should the substances follow and what can be said to the patient in terms of limits of confidentiality and how the information will be protected and used?
3. What other issues related to substances need to be considered in this section?

4.52

Day 2 Wrap-up

4.53

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UTC 5
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MODULE 4—ASSESSMENT
THE COLOMBO PLAN
DAP
Drug Advisory Programme

Comprehensive Assessment: ASI Domains

Legal status

4.55

ASI Legal Section

To gather basic information about:

- Legal History
- Information About Probation & Parole
- Charges, Convictions, & Incarcerations
- Illegal Activities
- Desire, Need for Legal Counsel

4.56

Remember there is the ASI-Crime (ASI-C)

- If you need more detailed information about legal issues, the Addiction Severity Index, the ASI-C asks more detailed information on legal issues

- Crimes and motives
- The feelings about the crime
- Family impact of the crimes
- Friends who commit crimes

https://www.emcdda.europa.eu/html.cfm/index3572EN.html

4.57

Comprehensive Assessment: ASI Domains

Family/social status

4.58

ASI Family/Social Section

To gather basic information about:

- This section examines the nature of the client's personal relationships and marital and living status
- Determines if the client has relationship problems with family, friends, or others
- Documents the client's satisfaction with their current status

4.59

Additional Measure If Needed: Multidimensional Scale of Perceived Social Support (MSPSS)

- Brief questionnaire designed to measure perceptions of support from 3 sources: Family
- Friends
- Significant Other
- The scale is comprised of a total of 12 items, with 4 items for each subscale.

Zimet GD, Dahlem NW, Zimet SG, Farley GK. The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment 1988;52:30-41.

4.60

Additional Measure If Needed: Family APGAR

- Assessing family function
- 5-item questionnaire
- Measures the family member's satisfaction with each of the five basic components of family function
- Widely used in primary care settings.

		DESCRIPTION
A	Adaptation	The capability of the family to utilize and share inherent resources.
P	Partnership	Measures the satisfaction attained in solving problems by communication.
G	Growth	Refers to the freedom of change both physical and emotional growth.
A	Affection	It is the intimacy and emotional interaction in the family.
R	Resolve	The member's satisfaction with the commitment made by other members of the family.

Hiroaki Takenaka, Nobutaro Ban (2016). The most important question in family approach: the potential of the resolve item of the family APGAR in family medicine. Asia Pac Fam Med. 2016; 15: 3. Published online 2016 May 5. doi: 10.1186/s12930-016-0028-9

4.61

Large Group Discussion– Legal and Family/Social Questions?

Discuss

1. What would need to be modified or added to best capture the legal needs to ne addressed in the people you serve?
2. What family and social issues also need to be considered for the most complete and useful comprehensive assessment?

4.62

Comprehensive Assessment: ASI Domains

Psychiatric status

4.63

ASI Psychiatric Status Section

- To gather basic information about:
- **Symptoms of psychological and emotional distress**
- **Symptoms associated exclusively with results of ingesting a drug or detoxification should not be recorded**

4.64

ASI Psychiatric Status Section (Continued)

- **To determine long-term and recent psychological and emotional functioning**
- **To document current and past history of treatment**
- **To explore the potential for the need for further evaluation or referral**

4.65

If a Personality Issue Is a Concern

International Personality Disorder Examination (I.P.D.E.)

- Each module (DSM-IV™ and ICD-10) contains an IPDE Screening Questionnaire and the IPDE Semistructured Interview.
- The different descriptive criteria of the disorder are evaluated through a series of questions that refer to 6 areas of life: Job; Self; Relationships; Affections; Reality check; and Impulse control.

https://apps.who.int/iris/bitstream/handle/10665/41912/9780521041669.pdf;sequence=1

4.66

Domains of Comprehensive Assessment

Other Issues

4.67

Montreal Cognitive Assessment (MoCA)

- Cognitive screening test
- The MoCA assesses:
  - Short term memory
  - visuospatial abilities
  - executive functions
  - attention
  - concentration
  - working memory
  - language
  - orientation to time and place
- Suitable for people with substance use disorder.

https://www.mocatest.org/pdf_files/test/MoCA-Test-English_7_1.pdf
Copersino, M. et al., (2009) Rapid Cognitive Screening of Patients With Substance Use Disorders. *Experimental and Clinical Psychopharmacology*, Vol. 17, N° 5, 337-344 (DOI: 10.1037/a0017260)

4.68

Disability Assessment Schedule WHODAS 2.0

- Generic assessment instrument that provides a standardized method for measuring health and disability
- Measures the level of functioning in six domains of life:
  - Cognition
  - Mobility
  - Self-care
  - Getting along
  - Life activities
  - Participation

World Health Organization 2010. Measuring Health and Disability: Manual for WHO Disability Assessment Schedule (WHODAS 2.0) / edited by TB Üstün, N Kostanjsek, S Chatterji, J Rehm. Avaliable at: https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health/who-disability-assessment-schedule

4.69

Small Group Exercise

- Looking at the material about the ASI and other measures, what specific issues, questions or areas do you need to add to a comprehensive assessment based upon the community or program in which you work?

4.70

Break

15 minutes

4.71

Resource Page 4.1:

The first domain of Comprehensive Assessment: "Nature and Severity of Substance Use and Problems"

1. Nature and Severity of Substance Use: _____

_____

_____

2. Mental Health: _____

_____

_____

3. Physical Health: _____

_____

_____

4. Social Functioning: _____

_____

_____

5. Family Functioning: _____

_____

_____

6. Transgression to the Law and Social Standard: _____

_____

_____

Resource Page 4.2: The Addiction Severity Index

Addiction Severity Index 5th Edition

Clinical/Training Version

A. Thomas McLellan, Ph.D.
Deni Carise, Ph.D.
Thomas H. Coyne, MSW

Remember: This is an interview, not a test

≈Item numbers circled are to be asked at follow-up.≈
≈Items with an asterisk are cumulative and should be rephrased at follow-up.≈

INTRODUCING THE ASI: Introduce and explain the seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychiatric. All clients receive this same standard interview. All information gathered is confidential; explain what that means in your facility; who has access to the information and the process for the release of information.
There are two time periods we will discuss:

1. The past 30 days
2. Lifetime

Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.
The scale is:
0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely
Inform the client that he/she has the right to refuse to answer any question. If the client is uncomfortable or feels it is too personal or painful to give an answer, instruct the client not to answer. Explain the benefits and advantages of answering as many questions as possible in terms of developing a comprehensive and effective treatment plan to help them.

Please try not give inaccurate information!

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
   N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. Tutorial/clarification notes are preceded with "•".

HALF TIME RULE: If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS:
⇒ Last two items in each section.
⇒ Do not over-interpret.
⇒ Denial does not necessarily warrant misrepresentation.
⇒ Misrepresentation = overt contradiction in information.

Probe, cross-check and make plenty of comments!

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.
2. Business managers if medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, small businesses (bank teller, bookkeeper, clerk, draftsperson, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeperson, chef, electrician, fireman, machinist, mechanic, paperhanger, painter, repairperson, tailor, welder, police, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Dilaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Syrups = Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinal
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate, Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine or Crack, and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Psilocybin (Mushrooms), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstacy
Inhalants:	Nitrous Oxide (Whippits), Amyl Nitrite (Poppers), Glue, Solvents, Gasoline, Toluene, Etc.

Just note if these are used:
Antidepressants,
Ulcer Meds = Zantac, Tagamet
Asthma Meds = Ventolin Inhaler, Theodur
Other Meds = Antipsychotics, Lithium

ALCOHOL/DRUG USE INSTRUCTIONS:

The following questions refer to two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days.

⇒30 day questions only require the number of days used.
⇒Lifetime use is asked to determine extended periods of use.
⇒Regular use = 3 or more times per week, binges, or problematic irregular use in which normal activities are compromised.
⇒Alcohol to intoxication does not necessarily mean "drunk", use the words "to feel or felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule, 3 or more drinks in one sitting, or 5 or more drinks in one day defines "intoxication".
⇒ How to ask these questions:
→ "How many days in the past 30 have you used....?"
→ "How many years in your life have you regularly used....?"

Addiction Severity Index, Fifth Edition
GENERAL INFORMATION

(Clinical/Training Version)

G1.ID No.: ☐☐☐☐☐☐☐☐☐

G2. SS No. : ☐☐☐ - ☐☐ - ☐☐☐☐

G4. Date of Admission ☐☐ / ☐☐ / ☐☐☐☐

G5. Date of Interview: ☐☐ / ☐☐ / ☐☐☐☐

G6 Time Begun: (Hour: Minutes) ☐☐ : ☐☐

G7. Time Ended: (Hour:Minutes) ☐☐ : ☐☐

G8. Class: 1. Intake 2. Follow-up ☐

G9. Contact Code: 1. In person
2. Telephone (Intake ASI must be in person) ☐

G10. Gender: 1. Male 2. Female ☐

G11. Interviewer Code No./ Initials: ☐☐☐

_____
Name

_____
Address 1

_____
Address 2

_____(____)_____
City State Zip Code Telephone Number

G14. How long have you lived at this address? ☐☐ / ☐☐
Years Months

G15. Is this residence owned by you or your family? 0-No 1-Yes ☐

G16. Date of birth: (Month/Day/Year) ☐☐/☐☐/☐☐☐☐

G17. Of what race do you consider yourself? ☐
1. White (not Hisp) 5. Asian/Pacific 9. Other Hispanic
2. Black (not Hisp) 6. Hispanic-Mexican
3. American Indian 7. Hispanic-Puerto Rican
4. Alaskan Native 8. Hispanic-Cuban

G18. Do you have a religious preference? ☐
1. Protestant 3. Jewish 5. Other
2. Catholic 4. Islamic 6. None

G19. Have you been in a controlled environment in the past 30 days? ☐
1. No 4. Medical Treatment
2. Jail 5. Psychiatric Treatment
3. Alcohol/Drug Treat. 6. Other: _____
•A place, *theoretically*, without access to drugs/alcohol.

G20. How many days? ☐☐
•"NN" if Question G19 is No. Refers to total number of days detained in the past 30 days.

ADDITIONAL TEST RESULTS

_____ ☐☐☐
_____ ☐☐☐
_____ ☐☐
_____ ☐☐☐
_____ ☐☐
_____ ☐☐☐
_____ ☐☐☐
_____ ☐☐☐
_____ ☐☐☐

PROBLEMS	SEVERITY PROFILE									
	0	1	2	3	4	5	6	7	8	9
MEDICAL										
EMP/SUP										
ALCOHOL										
DRUGS										
LEGAL										
FAM/SOC										
PSYCH										

GENERAL INFORMATION COMMENTS
(Include the question number with your notes)

MEDICAL STATUS

M1. * How many times in your life have you been hospitalized for medical problems? ☐☐

- Include O.D.'s and D.T.'s. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of ***overnight*** hospitalizations for medical problems.

M2. How long ago was your last hospitalization for a physical problem? ☐☐ Yrs. ☐☐ Mos.

- If no hospitalizations in Question M1, then this is coded "NN".

M3. Do you have any chronic medical problems which continue to interfere with your life? 0 -No 1 - Yes ☐

- ***If "Yes", specify in comments.***
- A chronic medical condition is a serious physical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of their abilities.

M4. Are you taking any prescribed medication on a regular basis for a physical problem? 0 - No 1 - Yes ☐

- ***If Yes, specify in comments.***
- Medication prescribed by a MD for medical conditions; ***not psychiatric medicines***. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.

M5. Do you receive a pension for a physical disability? 0 - No 1 - Yes ☐

- ***If Yes, specify in comments.***
- Include Workers' compensation, exclude psychiatric disability.

M6. How many days have you experienced medical problems in the past 30 days? ☐☐

- Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).

For Questions M7 & M8, ask the patient to use the Patient Rating scale.

M7. How troubled or bothered have you been by these medical problems in the past 30 days? ☐

- Restrict response to problem days of Question M6.

M8. How important to you now is treatment for these medical problems? ☐

- If client is currently receiving medical treatment, refer to the need for ***additional*** medical treatment by the patient.

INTERVIEWER SEVERITY RATING

M9. How would you rate the patient's need for medical treatment? ☐

- Refers to the patient's need for ***additional*** medical treatment.

CONFIDENCE RATINGS

Is the above information significantly distorted by:

M10. Patient's misrepresentation? 0 - No 1 - Yes ☐

M11. Patient's inability to understand? 0 - No 1 - Yes ☐

MEDICAL COMMENTS

(Include question number with your notes)

EMPLOYMENT/SUPPORT STATUS

E1.* Education completed:
- GED = 12 years, note in comments.
- Include formal education only.

Yrs. ☐☐ Mos. ☐☐

E2.* Training or Technical education completed:
- Formal/organized training only. For military training, only include training that can be used in civilian life (i.e., electronics, computers)

Mos. ☐☐

E3. Do you have a profession, trade, or skill? 0 - No 1 - Yes ☐
- Employable, transferable skill acquired through training.
- If "Yes" (specify) _____

E4. Do you have a valid driver's license?
- Valid license; not suspended/revoked. 0 - No 1 - Yes ☐

E5. Do you have an automobile available for use?
- If answer toE4 is "No", then E5 must be "No". 0 - No 1 - Yes ☐
Does not require ownership, only requires availability on a regular basis.

E6. How long was your longest full time job?
- Full time = 35+ hours weekly; does not necessarily mean most recent job.

Yrs. ☐☐ Mos. ☐☐

E7.* Usual (or last) occupation? (specify) _____ ☐
(use Hollingshead Categories Reference Sheet)

E8. Does someone contribute to your support in any way? 0 - No 1 - Yes ☐
- Is patient receiving any regular support (i.e., cash, food, housing) from family/friend. Include spouse's contribution; exclude support by an institution.

E9 Does this constitute the majority of your support? 0 - No 1 - Yes ☐
- If E8 is "No", then E9 is "N" .

E10. Usual employment pattern, past three years? ☐
1. Full time (35+ hours)
2. Part time (regular hours)
3. Part time (irregular hours)
4. Student
5. Service
6. Retired/Disability
7. Unemployed
8. In controlled environment
- Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents the current situation.

E11. How many days were you paid for working in the past 30? ☐☐
- Include "under the table" work, paid sick days and vacation.

EMPLOYMENT/SUPPORT COMMENTS
(Include question number with your notes)

EMPLOYMENT/SUPPORT (cont.)

For questions E12-17: How much money did you receive from the following sources in the past 30 days?

E12. Employment? ☐☐☐☐☐
- Net or "take home" pay, include any "under the table" money.

E13. Unemployment Compensation? ☐☐☐☐☐

E14. Welfare? ☐☐☐☐☐
- Include food stamps, transportation money provided by an agency to go to and from treatment.

E15. Pensions, benefits or Social Security? ☐☐☐☐☐
- Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.

E16. Mate, family, or friends? ☐☐☐☐☐
- Money for personal expenses, (i.e. clothing), include unreliable sources of income. Record ***cash*** payments only, include windfalls (unexpected), money from loans, legal gambling, inheritance, tax returns, etc.).

E17. Illegal? ☐☐☐☐☐
- ***Cash*** obtained from drug dealing, stealing, fencing stolen goods, illegal gambling, prostitution, etc. ***Do not*** attempt to convert drugs exchanged to a dollar value.

E18. How many people depend on you for the majority of their food, shelter, etc.? ☐☐
- Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

E19. How many days have you experienced employment problems in the past 30 ? ☐☐
- Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.

For Questions E20 & E21, ask the patient to use the Patient Rating scale.

E20. How troubled or bothered have you been by these employment problems in the past 30 days? ☐
- If the patient has been incarcerated or detained during the past 30 days, they cannot have employment problems. In that case an "N" response is indicated.

E21. How important to you now is counseling for these employment problems? ☐
- Stress help in finding or preparing for a job, not giving them a job.

INTERVIEWER SEVERITY RATING

E22. How would you rate the patient's need for employment counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

E23. Patient's misrepresentation? 0-No 1-Yes ☐

E24. Patient's inability to understand? 0-No 1-Yes ☐

EMPLOYMENT/SUPPORT COMMENTS
(Include question number with your notes)

ALCOHOL/DRUGS

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

• Note the usual or most recent route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.

		Past 30 Days	Lifetime (years)	Route of Admin
D1	Alcohol (any use at all, 30 days)			
D2	Alcohol - to intoxication			
D3	Heroin			
D4	Methadone			
D5	Other Opiates/Analgesics			
D6	Barbiturates			
D7	Sedatives/Hypnotics/ Tranquilizers			
D8	Cocaine			
D9	Amphetamines			
D10	Cannabis			
D11	Hallucinogens			
D12	Inhalants			
D13	More than 1 substance per day (including alcohol)			

D14. According to the interviewer, which substance(s) is/are the major problem? ☐☐

- Interviewer should determine the major drug or drugs of abuse. Code the number next to the drug in questions 01-12, or "00" = no problem, "15" = alcohol & one or more drugs, "16" = more than one drug but no alcohol. Ask patient when not clear.

D15. How long was your last period of voluntary abstinence from this major substance? ☐☐ Mos.

- Last attempt of at least one month, not necessarily the longest. Periods of hospitalization/incarceration ***do not count***. Periods of antabuse, methadone, or naltrexone use during abstinence ***do count***.
- "00" = never abstinent

D16. How many months ago did this abstinence end? ☐☐ Mos.

- If D15 = "00", then D16 = "NN".
- "00" = still abstinent.

D17* How many times have you had: Alcohol DT's? ☐☐

- ***Delirium Tremens*** (DT's): Occur 24-48 hours after last drink, or significant decrease in alcohol intake, shaking, severe disorientation, fever, hallucinations, they usually require medical attention.

D18* Overdosed on Drugs? ☐☐

- ***Overdoses*** (OD): Requires intervention by someone to recover, not simply sleeping it off, include suicide attempts by OD.

ALCOHOL/DRUGS COMMENTS
(Include question number with your notes)

Page 5

ALCOHOL/DRUGS (cont.)

How many times in your life have you been treated for :

D19.* Alcohol abuse? ☐☐

•Include detoxification, halfway houses, in/outpatient counseling, and AA (if 3+ meetings within one month period).

How many of these were detox only:

D21.* Alcohol? ☐☐

How much would you say you spent during the past 30 days on:

D23. Alcohol? ☐☐☐☐☐

How many times in your life have you been treated for :

D20.* Drug abuse? ☐☐

• Include detoxification, halfway houses, in/outpatient counseling, and NA (if 3+ meetings within one month period).

How many of these were detox only:

D22.* Drugs? ☐☐

• If D19 = "00", then question D21 is "NN"
If D20 = '00', then question D22 is "NN"

How much would you say you spent during the past 30 days on:

D24. Drugs? ☐☐☐☐☐

• Only count actual ***money*** spent. What is the financial burden caused by drugs/alcohol?

D25. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days? • Include AA/NA ☐☐

How many days in the past 30 have you experienced:

D26. Alcohol problems? ☐☐

• Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D28+D30, ask the patient to use the Patient Rating scale. The patient is rating the need for additional substance abuse treatment.

How troubled or bothered have you been in the past 30 days by these:

D28. Alcohol problems? ☐

• Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

How important to you now is treatment for these:

D30. Alcohol problems? ☐

How many days in the past 30 have you experienced:

D27. Drug problems? ☐☐

• Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D29+D31, ask the patient to use the Patient Rating scale. The patient is rating the need for additional substance abuse treatment.

How troubled or bothered have you been in the past 30 days by these:

D29. Drug problems? ☐

How important to you now is treatment for these:

D31. Drug problems? ☐

INTERVIEWER RATING

How would you rate the patient's need for treatment for:

D32. Alcohol problems? ☐

D33. Drug problems? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

D34. Patient's misrepresentation? 0-No 1-Yes ☐

D35. Patient's inability to understand? 0-No 1-Yes ☐

ALCOHOL/DRUGS COMMENTS

(Include question number with your notes)

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system? 0 - No 1 -Yes
- Judge, probation/parole officer, etc.

L2. Are you on parole or probation?
- Note duration and level in comments. 0 - No 1 - Yes

How many times in your life have you been arrested and charged with the following:

L3 * Shoplift/Vandal		L10* Assault	
L4 * Parole/Probation Violations		L11* Arson	
L5 * Drug Charges		L12* Rape	
L6 * Forgery		L13* Homicide/Mansl.	
L7* Weapons Offense		L14* Prostitution	
L8* Burglary/Larceny/B&E		L15* Contempt of Court	
L9 * Robbery		L16* Other: _____	

- Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult.
- Include formal charges only.

L17* How many of these charges resulted in convictions?
- If L3-16 = 00, then question L17 = "NN".
- Do not include misdemeanor offenses from questions L18-20 below.
- Convictions include fines, probation, incarcerations, suspended sentences, guilty pleas, and plea bargaining.

How many times in your life have you been charged with the following:

L18.* Disorderly conduct, vagrancy, public intoxication?

L19.* Driving while intoxicated?

L20.* Major driving violations?
- Moving violations: speeding, reckless driving, no license, etc.

L21* How many months were you incarcerated in your life? Mos.
- If incarcerated 2 weeks or more, round this up to 1 month. List total number of months incarcerated.

L22. How long was your last incarceration? Mos.
- Of 2 weeks or more. Enter "NN" if never incarcerated.

L23. What was it for?
- Use code 03-16, 18-20. If multiple charges, choose most severe. Enter "NN" if never incarcerated.

L24. Are you presently awaiting charges, trial, or sentence? 0 - No 1 - Yes

L25. What for?
- Use the number of the type of crime committed: 03-16 and 18-20
- Refers to Q. L24. If more than one, choose most severe.

LEGAL COMMENTS
(Include question number with your notes)

Page 7

LEGAL STATUS (cont.)

L26. How many days in the past 30, were you detained or incarcerated? ☐☐
- Include being arrested and released on the same day.

L27. How many days in the past 30 have you engaged in illegal activities for profit? ☐☐
- Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross checked with Question E17 under Employment/Family Support Section.

For Questions L28-29, ask the patient to use the Patient Rating scale.

L28. How serious do you feel your present legal problems are? ☐
- Exclude civil problems

L29. How important to you now is counseling or referral for these legal problems? ☐
- Patient is rating a need for referral to legal counsel for defense against criminal charges.

INTERVIEWER SEVERITY RATING

L30. How would you rate the patient's need for legal services or counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

L31. Patient's misrepresentation? 0 - No 1- Yes ☐

L32. Patient's inability to understand? 0 - No 1 - Yes ☐

LEGAL COMMENTS
(Include question number with your notes)

FAMILY HISTORY

Have any of your blood-related relatives had what you would call a significant drinking, drug use, or psychiatric problem? Specifically, was there a problem that did or should have led to treatment?

Mother's Side	Alcohol	Drug	Psych.
H1 .Grandmother	☐	☐	☐
H2. Grandfather	☐	☐	☐
H3. Mother	☐	☐	☐
H4. Aunt	☐	☐	☐
H5. Uncle	☐	☐	☐

Father's Side	Alcohol	Drug	Psych.
H6. Grandmother	☐	☐	☐
H7. Grandfather	☐	☐	☐
H8. Father	☐	☐	☐
H9. Aunt	☐	☐	☐
H10. Uncle	☐	☐	☐

Siblings	Alcohol	Drug	Psych.
H11. Brother	☐	☐	☐
H12. Sister	☐	☐	☐

0 = Clearly No for any relatives in that category **X = Uncertain or don't know**
1 = Clearly Yes for any relatives in that category **N = Never was a relative**

- In cases where there is more than one person for a category, record the occurrence of problems for *any* in that group. Accept the patient's judgment on these questions.

FAMILY HISTORY COMMENTS

FAMILY/SOCIAL STATUS

F1. Marital Status:
1-Married 3-Widowed 5-Divorced
2-Remarried 4-Separated 6-Never Married
• Common-law marriage = 1. Specify in comments. ☐

F2. How long have you been in this marital status (Q #F1)? ☐☐ Yrs. ☐☐ Mos.
• If never married, then since age 18.

F3. Are you satisfied with this situation? 0-No 1-Indifferent 2-Yes ☐
• Satisfied = generally liking the situation.
• Refers to Questions F1 & F2.

F4.* Usual living arrangements (past 3 years): ☐
1-With sexual partner & children
2-With sexual partner alone
3-With children alone
4-With parents
5-With family
6-With friends
7-Alone
8-Controlled Environment
9-No stable arrangement
• Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.

F5. How long have you lived in these arrangements? ☐☐ Yrs. ☐☐ Mos.
• If with parents or family, since age 18.
• Code years and months living in arrangements from Question F4.

F6. Are you satisfied with these arrangements? 0-No 1-Indifferent 2-Yes ☐

Do you live with anyone who:

F7. Has a current alcohol problem? 0-No 1-Yes ☐

F8 Uses non-prescribed drugs? 0-No 1-Yes ☐
(or abuses prescribed drugs)

F9. With whom do you spend most of your free time? 1-Family 2-Friends 3-Alone ☐
• If a girlfriend/boyfriend is considered as family by patient, then they must refer to them as family throughout this section, not a friend.

F10. Are you satisfied with spending your free time this way ? 0-No 1-Indifferent 2-Yes ☐
• A satisfied response must indicate that the person generally likes the situation. Referring to Question F9.

F11. How many close friends do you have? ☐
• Stress that you mean ***close***. Exclude family members. These are "reciprocal" relationships or mutually supportive relationships.

Would you say you have had a close reciprocal relationship with any of the following people:

F12. Mother ☐ F15. Sexual Partner/Spouse ☐

F13. Father ☐ F16. Children ☐

F14. Brothers/Sisters ☐ F17. Friends ☐

0 = Clearly No for all in class X = Uncertain or "I don't know
1 = Clearly Yes for any in class N = Never was a relative
• By reciprocal, you mean "that you would do anything you could to help them out and vice versa".

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FAMILY/SOCIAL COMMENTS
(Include question number with your notes)

FAMILY/SOCIAL (cont.)

Have you had significant periods in which you have experienced serious problems getting along with: **0 – No, 1 - Yes**

	Past 30 days	In Your Life
F18. Mother	☐	☐
F19. Father	☐	☐
F20. Brother/Sister	☐	☐
F21. Sexual Partner/Spouse	☐	☐
F22. Children	☐	☐
F23. Other Significant Family (specify)_____	☐	☐
F24. Close Friends	☐	☐
F25. Neighbors	☐	☐
F26. Co-workers	☐	☐

- "Serious problems" mean those that endangered the relationship.
- A "problem" requires contact of some sort, either by telephone or in person. If no contact code "N"

Has anyone ever abused you? **0- No 1-Yes**

	Past 30 days	In Your Life
F27. Emotionally? • Made you feel bad through harsh words.	☐	☐
F28. Physically? • Caused you physical harm.	☐	☐
F29. Sexually? • Forced sexual advances/acts.	☐	☐

How many days in the past 30 have you had serious conflicts:

F30. With your family? ☐☐

For Questions F32-35, ask the patient to use the Patient Rating scale.

How troubled or bothered have you been in the past 30 days by:

F32. Family problems ? ☐

How important to you now is treatment or counseling for these:

F34. Family problems ☐
- Patient is rating his/her need for counseling for family problems, not whether they would be willing to attend.

How many days in the past 30 have you had serious conflicts:

F31. With other people (excluding family)? ☐☐

For Questions F32-35, ask the patient to use the Patient Rating scale.

How troubled or bothered have you been in the past 30 days by:

F33. Social problems? ☐

How important to you now is treatment or counseling for these:

F35. Social problems ☐
- Include patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems.

INTERVIEWER SEVERITY RATING

F36. How would you rate the patient's need for family and/or social counseling? ☐

CONFIDENCE RATING

Is the above information significantly distorted by:

F37. Patient's misrepresentation? 0-No 1-Yes ☐

F38. Patient's inability to understand? 0-No 1-Yes ☐

FAMILY/SOCIAL COMMENTS

(Include question number with your notes)

PSYCHIATRIC STATUS

How many times have you been treated for any psychological or emotional problems:

P1* In a hospital or inpatient setting? ☐☐

P2* Outpatient/private patient? ☐☐

- Do not include substance abuse, employment, or family counseling. Treatment episode = a series of more or less continuous visits or treatment days, not the number of visits or treatment days.
- Enter diagnosis in comments if known.

P3. Do you receive a pension for a psychiatric disability? 0-No 1-Yes ☐

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

		0-No Past 30 Days	1-Yes Lifetime
P4.	Experienced serious depression-sadness, hopelessness, loss of interest?	☐	☐
P5.	Experienced serious anxiety/ tension-uptight, unreasonably worried, inability to feel relaxed?	☐	☐
P6.	Experienced hallucinations-saw things/ heard voices that others didn't see/hear?	☐	☐
P7.	Experienced trouble understanding, concentrating, or remembering?	☐	☐

Have you had a significant period of time (despite your alcohol and drug use) in which you have:

		0-No Past 30 Days	1-Yes Lifetime
P8.	Experienced trouble controlling violent behavior including episodes of rage, or violence? • Patient can be under the influence of alcohol / drugs.	☐	☐
P9.	Experienced serious thoughts of suicide? • Patient seriously considered a plan for taking his/her life. Patient can be under the influence of alcohol/drugs.	☐	☐
P10.	Attempted suicide? • Include actual suicidal gestures or attempts. • Patient can be under the influence of alcohol / drugs.	☐	☐
P11.	Been prescribed medication for any psychological or emotional problems? • Prescribed for the patient by a physician. Record "Yes" if a medication was prescribed even if the patient is not taking it.	☐	☐

P12. How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐
- This refers to problems noted in Questions P4-P10.

For Questions P13-P14, ask the patient to use the Patient Rating scale

P13. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐
- Patient should be rating the problem days from Question P12.

P14. How important to you now is treatment for these psychological or emotional problems? ☐

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PSYCHIATRIC STATUS COMMENTS
(Include question number with your comments)

PSYCHIATRIC STATUS (cont.)

The following items are to be completed by the interviewer:

At the time of the interview, the patient was:	**0-No 1-Yes**
P15. Obviously depressed/withdrawn	☐
P16. Obviously hostile	☐
P17. Obviously anxious/nervous	☐
P18. Having trouble with reality testing, thought disorders, paranoid thinking	☐
P19. Having trouble comprehending, concentrating, remembering	☐
P20. Having suicidal thoughts	☐

INTERVIEWER SEVERITY RATING

P21 . How would you rate the patient's need for psychiatric/psychological treatment? ☐

CONFIDENCE RATING

Is the above information significantly distorted by:

P22	Patient's misrepresentation?	0-No 1-Yes ☐
P23.	Patient's inability to understand?	0-No 1-Yes ☐

G12. Special Code ☐

1. Patient terminated by interviewer
2. Patient refused
3. Patient unable to respond (language or intellectual barrier, under the influence, etc.)

N. Interview completed.

PSYCHIATRIC STATUS COMMENTS

(Include question number with your notes)

ASI Response Card #1	
0	Not at all
1	Slightly
2	Moderately
3	Considerably
4	Extremely

PATIENT AND INTERVIEWER SEVERITY RATINGS

MEDICAL STATUS

Patient rating (please copy answer in this box from the answer that was given to M8).
M8. How important to you now is treatment for these medical problems? ☐

Interviewer Rating*
How would you rate the patient's need for medical treatment? See **ASI Interviewer Severity Ratings** to determine a single value to place in this box.
For example if you determine severity is 6-7, please use your judgment to write either a 6 or a 7 NOT 6-7. ☐

EMPLOYMENT/SUPPORT STATUS

Patient rating (please copy answer in this box from the answer that was given to E21)
E21. How important to you now is help for these employment problems? ☐

Interviewer Rating*
How would you rate the patient's need for employment counseling? See **ASI Interviewer Severity Ratings** determine a single value to place in this box.
For example if you determine severity is 4-5, please use your judgment to write either a 4 or a 5 NOT 4-5. ☐

ALCOHOL/DRUGS

Patient rating (please copy answer in this box from the answer that was given to D30)
D30. How important to you now is treatment for these drug problems? ☐

Interviewer Rating*
How would you rate the patient's need for drug treatment? See **ASI Interviewer Severity Ratings** to determine a single value to place in this box. For example if you determine severity is 4-5, please use your judgment to write either a 4 or a 5 NOT 4-5. ☐

Patient rating (please copy answer in this box from the answer that was given to D31)
D31. How important to you now is treatment for these alcohol problems? ☐

Interviewer Rating*
How would you rate the patient's need for alcohol treatment? See **ASI Interviewer Severity Ratings** to determine a single value to place in this box. For example if you determine severity is 4-5, please use your judgment to write either a 4 or a 5 NOT 4-5. ☐

LEGAL STATUS

Patient rating (please copy answer in this box from the answer that was given to L29)
L29. How important to you now is counseling or referral for these legal problems? ☐

Interviewer Rating* How would you rate the patient's need for legal services? See ASI Interviewer Severity Ratings to determine a single value to place in this box. For example if you determine severity is 4-5, please use your judgment to write either a 4 or a 5 NOT 4-5. ☐

FAMILY/SOCIAL STATUS

Patient rating (please copy answer in this box from the answer that was given to F35)
F35. How important to you now is treatment or counseling for these social problems? ☐

Interviewer Rating*
How would you rate the patient's need for family/social counseling? See ASI Interviewer Severity Ratings to determine a single value to place in this box. For example if you determine severity is 6-7, please use your judgment to write either a 6 or a 7 NOT 6-7. ☐

MENTAL HEALTH (PSYCHIATRIC) STATUS

Patient rating (please copy answer in this box from the answer that was given to P14)
P14. How important to you now is treatment for these psychological or emotional problems? ☐

Interviewer Rating*
How would you rate the patient's need for psychological or emotional problem counseling?
See ASI Interviewer Severity Ratings to determine a single value to place in this box. For example if you determine severity is 6-7, please use your judgment to write either a 6 or a 7 NOT 6-7. ☐

* For the purpose of this interview, **severity** will be defined as need for treatment where there currently is none; **or** for an **additional** form or type of treatment where the patient is currently receiving some form of treatment. These ratings should be based upon reports of amount, duration, and intensity of symptoms within a problem area. Please see the ASI Interviewer Severity Ratings card for the specific ratings. It is important to note that these ratings are not intended as estimates of the patient's **potential** benefit from treatment, but rather the extent to which some form of effective intervention is needed, regardless of whether that treatment is available or even in existence.

ASI Interviewer Severity Ratings	
0-1	No real problem, treatment not indicated
2-3	Slight problem, treatment probably not necessary
4-5	Moderate problem, some treatment indicated
6-7	Considerable problem, treatment necessary
8-9	Extreme problem, treatment absolutely necessary

Resource Page 4.3: Coding N Reference Sheet

Where can I code "Not Applicable" (N or NN) on the ASI?

General Information

If G9 = No, then G10 = NN

If G10 = 30, then E19 = NN

Medical Status Section

M14 = N if patient is male

If M14 is coded No or Unsure (0 or 2), then M14a = N

If M14 = Yes, then M14b = N

Employment/Support Status Section

If G10 = 30, then E19 = NN

If E19 = NN, E20 = N

Alcohol/Drugs Section

D1–D12: If both past-30-day use and lifetime use = 00, then route of administration = N

If D15 = 00, then D14c = No

Legal Status Section

If L3–L16 = 00, then L17 = NN

If L24 is coded No, then L25 is coded NN

Family/Social Status Section

F11a: If patient reports having no friends, F11a = N

If F11a = N, then F24 for past 30 days = N

F18–F26: Code N if the family/social contact does not exist (i.e., F22 for a client with no children or F20 for a client with no siblings)

If E11 in the Employment/Support Status section is 00, F26 for past 30 days = N

Mental Health (Psychiatric) Status Section

There are no circumstances under which an N would be coded in this section.

ADDICTION SEVERITY INDEX NARRATIVE REPORT

JOHN

Date of Birth:	07/30/1959	ID#	101
Social Security Number:	444 33 2211	Site ID#:	101001
Date of Interview:	08/26/2004	Time Int. Began:	10:51:21
Type of Interview:	Intake	Time Int. Ended	11:25:21
Interviewer Name:	Deni Carise	Interviewer ID#	01

GENERAL INFORMATION SECTION

The following is a clinical summary based on an in-person interview with John Smith, on 08/26/2004. This summary is based on the client's self report regarding lifetime and recent Medical, Employment, Alcohol, Drug, Legal, Family/Social and Psychiatric involvement and/or problems. Included in each of these sections is the interviewer's severity rating, suggesting the client's need for treatment (or additional treatment beyond what he's already receiving). This is based on the information provided by the client.

John is a 40 year old, white (non-Hispanic) male. He states his religious preference is Catholic. John reports he actively practices his faith and attends church every Sunday. He feels his spirituality will be a big part of his recovery. He has lived at his current address for approximately 3 years. Neither he nor his family owns this residence. John reports paying $600.00 month rent. John reports spending 2 of the past 30 days in a jail or prison facility in which his freedom was restricted and/or prohibited. This could have limited his ability to use alcohol or drugs, as well as his interactions with family and others. Client was arrested for driving under the influence and spent 2 nights in jail.

ALCOHOL & DRUG SECTION

Lifetime and Recent Alcohol Use:

In his lifetime, John drank regularly for a period of 15 years. For 7 years, his drinking was regular and heavy (generally defined as 5 or more drinks in one day). In the past 30 days, he drank 20 days, and has drank heavily, having more than five drinks per day, on each of those days. He reports having spent $100 on alcohol in the past 30 days. He has never experienced alcohol delirium tremens.

Lifetime and Recent Drug Use:

John has a history of ongoing heroin use for a period of 4 years, he also used methadone regularly for one year. John appears to have no lifelong problems with other opiates, additionally he reports no periods of ongoing barbiturate use. He has used sedatives, hypnotics, or tranquilizers regularly (generally defined as three times per week or more), for a period of 2 years. John reports using unprescribed Xanax for several years in the early 1980s. John has used cocaine regularly or problematically for a period of 8 years; he has no history of ongoing amphetamine use. John has a 15 year history of ongoing, regular cannabis use; he has no history of ongoing use of hallucinogens.

He has no history of regular or ongoing use of inhalants. John has a history of using multiple substances, on an ongoing basis, for a period of 15 years. He has never overdosed, either intentionally or unintentionally, on drugs.

In the past 30 days, John has used heroin 8 days and methadone on 2 days. He has been buying methadone on the street for past 6 months. John has not used any other opiates, barbiturates, or sedatives in the past 30 days. John has used cocaine 3 days in the past 30; he has not used amphetamines during this time. John has used cannabis 10 days in the past 30; he has not used any hallucinogens. He has not used any inhalants in the past month. John has used two or more drugs together (or drugs and alcohol) on 20 days in the past month. In the past 30 days, John reports that he spent $100 on alcohol and $300 on other drugs.

Alcohol and Drug Treatment History:

John has received treatment 2 times for alcohol problems. None of these were brief "detoxification" treatments. He attended outpatient programs 2 times in 1994. John has received treatment 2 times for drug problems; none were limited to detoxification. These occurred at the same time he was treated for alcohol use. John's last period of continuous abstinence from alcohol and drugs lasted for 6 months, ending approximately 60 months ago. He attended four outpatient sessions for drug or alcohol problems in the past 30 days. This may include AA, NA, or CA attendance. John's outpatient sessions were limited to 4 AA meetings in the past month.

Client Perception of Severity of Alcohol and Drug Problems and Desire for Treatment:

John experienced alcohol-related problems on 30 of the past 30 days and is bothered considerably by these problems. Obtaining alcohol treatment is extremely important to John. John experienced problems on 10 of the past 30 days related to drug use and is bothered considerably by these problems. Obtaining drug treatment is extremely important to John.

Interviewer Impressions and Recommendations - Alcohol and Drugs:

It is my impression that John understood all of the questions and that he did not deliberately misrepresent information about his drug or alcohol use and history. It is the interviewer's belief that both alcohol and drugs are his most significant substance abuse problem. He has an alcohol problem of substantial concern and help obtaining appropriate treatment is vital at this time. John has a drug problem of substantial concern and help obtaining appropriate treatment is necessary at this time.

Additional Alcohol and Drug Comments:

Client appears sincerely motivated to attain treatment for his alcohol and drug problems. He would like to be a better father to his children and resume friendship with his wife. He believes his use of alcohol and drugs is responsible for his problems with his family members.

FAMILY / SOCIAL SECTION

Marital and Living Situation for Majority of the Past Three Years:

John is currently divorced, and is generally satisfied with this situation. He has been divorced for about 4 years. John has lived alone for most of the past three years and appears to feel fairly indifferent to this circumstance. He has been in this living arrangement for about 4 years.

Recovery Environment and Social Contacts:

No one residing with him has problems with alcohol or drugs. John currently spends most of his free time alone and is generally dissatisfied with this situation. He would like to establish better relationships with his children and his ex-wife. He reports having 4 close friends on whom he can rely.

Relationship Problems Lifetime:

John reports that he has had close, long lasting relationships with family and friends in his lifetime. In his lifetime, he has had significant problems getting along with his partner, but not with his children. In his lifetime, he has not had any serious problems getting along with either his mother or father. He has not had serious problems getting along with other significant family members in his lifetime. He has not had any significant problems getting along with either siblings or close friends. He has not had any serious problems getting along with either neighbors or co-workers. John reports no history of emotional, physical, or sexual abuse in his life.

Relationship Problems Past Thirty Days:

In the past 30 days, he has had significant problems getting along with his partner, but not with his children. In the past 30 days, he has not had any serious problems getting along with his mother. He has not had significant problems getting along with either his siblings or close friends. He has not had any serious, recent problems getting along with co-workers. John has not experienced any recent emotional, physical, or sexual abuse.

Client Perception of Severity of Family and Social Problems and Desire for Treatment:

Overall, John reports having 10 days of family related problems in the past 30, and is considerably troubled by these problems. He considers his problems with ex-wife to be most pressing. Obtaining treatment for family difficulties is profoundly important to John. He reports experiencing no problems with others and is not troubled or bothered by social issues. Consequently, help obtaining treatment for social related difficulties is not important to John.

Interviewer Impressions and Recommendations - Family and Social:

It is my impression that John understood all of the questions and that he did not deliberately misrepresent this information. John has family or social problems of substantial concern and help is necessary at this time.

Additional Family & Social Comments:

John is considerably bothered by the lack of involvement in his children's lives. He and his ex-wife argue over the children and he does not see them as often as he would like. During this section of the interview, John's affect was sad and he had difficulty maintaining composure.

PSYCHIATRIC SECTION

Serious Emotional and Psychological Problems – Lifetime:

John does not have a significant past history of psychiatric problems. He does not have a history of being prescribed psychotropic medications. He does not have a history of treatment for psychological or emotional problems. He does not receive any financial compensation for a psychiatric disability.

Recent Serious Emotional and Psychological Problems:
John has had serious problems with depression in the past 30 days; he was not obviously depressed at the time of the interview. John acknowledges serious problems controlling violent behavior in the past 30 days; he was not hostile at the time of the interview. John reports he has trouble controlling his rage and anger toward ex-wife when she blocks his visits with children.

Client Perception of Severity of Emotional and Psychological Problems and Desire for Treatment:
John experienced psychological or emotional problems on 4 of the past 30 days, and is bothered by them. Obtaining psychological or emotional treatment is slightly important to him.

Interviewer Impressions and Recommendations - Psychiatric:
It is my impression that John understood all of the questions and that he did not deliberately misrepresent his psychological/emotional information. He appears to have a moderately severe psychological or emotional problem; treatment is needed.

Additional Psychiatric Comments:
Client states he has concerns that one day he is not going to be able to control himself if his wife continues to withhold the children from seeing him.

LEGAL SECTION

History of Charges and Arrests:
John's participation in this substance abuse evaluation was suggested by a representative from the criminal justice system. He was referred as a consequence of his recent DWI arrest. John reports being arrested and charged once with driving while intoxicated twice, and twice for drug crimes. The drug related crimes were 1991 and 1995 possession charges, both reduced and dropped. His most recent charge was 3 weeks ago, and the case is still pending. He was charged with burglary, larceny, or breaking & entering on one occasion; he has no robbery charges. This charge was in 1985, and he was convicted, served 3 months in jail, and paid a fine. John was charged with disorderly conduct, vagrancy, or public intoxication on one occasion (public intoxications, 1990); he has never been charged with contempt of court. He was convicted on at least 1 of these charges. John has a history of being incarcerated for 3 months. His incarceration lasted about 3 months and was for burglary/larceny/B&E.

Current Legal Involvement:
In the past 30 days, John was detained/incarcerated on 2 days; he did not engage in any illegal activities for profit. He is awaiting either charges, trial, or sentencing for driving while intoxicated. He is not on probation or parole.

Client Perception of Severity of Legal Problems and Desire for Treatment:
John is slightly bothered by his legal problems; nevertheless, he feels that counseling for his legal problems is not important.

Interviewer Impressions and Recommendations - Legal:
It is my impression that John understood all of the questions, and that he did not deliberately misrepresent his legal information. He appears to have a minor legal problem or concern, but counseling does not look as though it is necessary. John has legal counsel for his current charges.

Additional Legal Comments:
No comment.

MEDICAL SECTION

Medical History:
John was hospitalized once for medical problems. This hospitalization was 5 years ago. He reports this hospitalization was for a routine appendectomy in the summer of 1994. He has a chronic medical problem (asthma) and is prescribed medications (inhaler) for this problem. He does not receive any financial compensation for physical disabilities.

Client Perception of Severity of Medical Problems and Desire for Treatment:
John does not report any medical problems in the past 30 days, and is not bothered by medical problems. Help obtaining treatment is not important to him at this time.

Interviewer Impressions and Recommendations – Medical:
It is my impression that John understood all of the questions and that he did not deliberately misrepresent his medical information. He appears to have no need for medical treatment at this time.

Additional Medical Comments:
Client reports his overall health is very good. His asthma has been under control for several years now. He has expressed some concern regarding his alcohol and drug use and how that is affecting him physically.

EMPLOYMENT SECTION

Employment History:
John has worked full time for most of the past three years. John's longest full time job lasted for 14 years. He works for a construction company. The majority of his employment in the past few years has been skilled manual work.

Current Financial Resources:
John reports working 24 days and making $7200 income in the past month. He reports he usually works a six day week. He did not receive any income from either unemployment compensation, welfare, pensions, benefits, or social security in the past month. He has not received any money from family or friends in the past month. John says that he has not made any money illegally in the past month. John has 4 dependents for whom he is financially responsible. John pays support to wife and three children. No one contributes any cash, food, housing, etc. for his support.

Education, Training and Resources:
He completed 14 years of traditional schooling obtaining a high school diploma and taking some college level courses as well as receiving 12 months of technical or vocational training. John has the skill base necessary to acquire a job. He does carpentry and masonry work and completed training in these areas. He has a valid driver's license but does not have use of a car for employment purposes.

Client Perception of Severity of Employment Problems and Desire for Treatment:
Overall, he reports experiencing no problems related to obtaining or maintaining employment and is not troubled or bothered by employment related difficulties. Consequently, help obtaining treatment for employment related difficulties is not important to John.

Interviewer Impressions and Recommendations - Employment:
It is my impression that John understood all of the questions and that he did not deliberately misrepresent this information. He appears to have no need for employment counseling at this time.

Additional Employment Comments:
Client has had a very stable work history for the past fourteen years. He is very satisfied with this status and has no desire to pursue training or additional education.

Interviewer Comment

The above information is based on John Smith's responses to questions from the Addiction Severity Index interview and was completed on 08/26/2004. This information will be used to guide John's placement into treatment and to develop his specific treatment care plan.

(Interviewer's Name)

Source: http://ctndisseminationlibrary.org/PDF/88endmaterial.pdf retrieved on 15 June 2015

Module 4 - Assessment Summary

Assessment

- Assessment is more than gathering of information; it is the initiation of building a trusting, helping, healing relationship and the forging of an alliance upon which to build a plan responsive to the individual and the family's needs. While there is no question that the accuracy and quality of information that we gather is important, how the information is gathered is even more important. Assessment is primarily about building a relationship.

- In a recovery-oriented, person-centered approach, the challenge is to think more positive, inviting as well as affirming ways of responding to and engaging individuals and families seeking help. Focusing on the strengths rather than on the problem areas can help build trust, cooperation and meaningful involvement. Providing some form of orientation as to how services are provided, and the process of assessment and treatment planning can help reduce anxieties, begin to build the alliance and support the assessment.

- It differs from Assessment in the following ways:

  - **Screening** – is a process for evaluating the possible presence of a particular problem, while

  - **Assessment** – is a process of defining the nature of the problem, determining a diagnosis, and developing a specific treatment recommendations for addressing the problem or diagnosis. Assessment is broader in purpose and scope.

- Addictions have multiple interrelated dimensions. Knowing about one dimension of a person's substance use may not tell you what you need to know about the other dimensions to provide effective treatment.

- There is a document published by the Substance Abuse and Mental Health administration called the Technical Assistance Publication (TAP 21) addiction counseling Competencies The Knowledge, Skills, and Attitudes of Professional Practice. Within this document there are competencies that are provided for each aspect of a counselor's provision of substance use disorder treatment. Underpinning each competency there is a set of skills, knowledge and attitudes. To provide assessment, one needs to have four competencies.

1. **Let's look at the four assessment competencies outlined in TAP 21: Select and use a comprehensive assessment process that is sensitive to gender, race, ethnic culture, and disabilities;**

   Knowledge under this competency includes:

   - Basic concepts of test validity and reliability.

   - Current validated assessment instruments and protocols.

   - Appropriate use and limitations of standardized instruments.

- The range of life areas to be assessed in a comprehensive assessment.
- How age, developmental level, cognitive and behavioral functioning, racial and ethnic culture, gender, and disabilities can influence the validity and appropriateness of assessment instruments and interview protocols.

  Skills under this competency include:

  - Selecting and administering appropriate assessment instruments and protocols within the counselor's scope of practice.
  - Introducing and explaining the purpose of assessment.
  - Addressing client perceptions and providing appropriate explanations of issues being discussed.
  - Conducting comprehensive assessment interviews and collecting information from collateral sources.

  Attitudes under this competency include:

  - Respect for the limits of assessment instruments and one's ability to interpret them.
  - Willingness to refer for additional specialized assessment.

- **Analyze and interpret the data to determine treatment recommendations;**

Knowledge under this competency includes

- Appropriate scoring methodology for assessment instruments.
- How to analyze and interpret assessment results.
- The range of available treatment options. Skills under this competency includes
- Scoring assessment tools.
- Interpreting data relevant to the client.
- Using results to identify client needs and appropriate treatment options.
- Communicating recommendations to the client and appropriate service providers Attitudes under this competency includes
- Respect for the value of assessment in determining appropriate treatment plans.

- **Seek appropriate supervision and consultation; and**

Knowledge under this competency includes

- The counselor's role, responsibilities, and scope of practice.
- The limits of the counselor's training and education.

- The supervisor's role and how supervision can contribute to quality assurance and improvement of clinical skills.
- Available consultation services and roles of consultants.
- The multidisciplinary assessment approaches.

Skills under this competency includes

- Recognizing the need for review by or assistance from a supervisor.
- Recognizing when consultation is appropriate.
- Providing appropriate documentation.
- Communicating oral and written information clearly.
- Incorporating information from supervision and consultation into assessment findings. Attitudes under this competency includes
- Commitment to professionalism.
- Acceptance of one's own personal and professional limitations.
- Willingness to continue learning and improving clinical skills.

■ **Document assessment findings and recommendations.**

Knowledge under this competency includes

- Agency-specific protocols and procedures.
- Appropriate terminology and abbreviations.
- Legal implications of actions and documentation.
- How to apply confidentiality rules and regulations and clients' rights to privacy. Skills under this competency includes
- Providing clear, concise, and legible documentation.
- Incorporating information from various sources.
- Preparing and clearly presenting, in oral and written form, assessment findings to the client and other professionals within the bounds of confidentiality rules and regulations.

Attitudes under this competency includes

- Recognition of the value of accurate documentation

In this module we will explore these competencies by introducing the Addiction Severity Index.

Please look for the Quality Assurance in treatment for drug use disorders: key quality

standards for service appraisal by the UNODC, WHO, African Union, Colombo Plan, Copolad and OAS CICAD. There is a section of standards that covers the areas covered in this training. Standards PC1, PC2, PC3, PC4 and PC5 are critical here. For example,

- PC1. Patient assessments are comprehensive and participatory
- PC2. Treatment and care provided based on informed consent from patients
- PC3. All patients have a written individual treatment plan that is regularly reviewed and helps co-ordinate treatment and care
- PC4. The service works in partnership with other services to meet patient needs
- PC5. The service meets the needs of diverse groups of patients

- As outlined in Principle 2 entitled, "Ensuring Ethical Standards of Care in Treatment Services" of the International Standards for the Treatment of Drug Use Disorders, informed consent of the person who is seeking treatment is essential.
- Screening, initial assessment, comprehensive assessment, and subsequent treatment activities must be voluntary, based on the patient's informed consent and their right to withdraw from participation at any stage.
- As a reminder, it important that you ensure the confidentiality of the responses and obtain their consent to proceed before conducting each step of the process from screening to assessment and for treatment, once the recommended treatment options are known based upon the screening and assessment results. Consent should be seen as important for each part of the process. It is important to make sure that the approach to consent to a particular treatment has parity with other healthcare. For example, there should be a consent for screening, a consent for assessment and then a consent after an assessment when treatment options are provided based on assessment results - such an approach is described in the Key Quality Standards from the WHO and the UN in 2021.

Initial Assessment:

- The purpose of an initial assessment is to identify critical information for the decision making about the level of care a person requires and to provide a baseline of his/her functioning when entering treatment.
- The dimensions examined in the initial Assessment will be further explored in the Comprehensive Assessment, which then informs the design of an Individualized Treatment Plan.
- Remember that assessment is a process, it is not a one-time event

The dimensions to be evaluated at this first stage are only the essential pieces of information needed to ensure the person qualifies for services: These are examples of dimensions commonly assessed.

These are examples of dimensions commonly assessed.

1. **Substance use**

Inquire about substance use sometime in life and in the last 12 months, type of substances used, frequency and intensity of use, associated problems identified by the person; and clinical indicators of substance use disorder.

It also seeks to know whether the person has tried to reduce or refrain from substance use, whether he/she succeeded in that effort; and whether he/she have engaged in previous treatments.

Finally, the risk of presenting a severe deprivation syndrome is explored.

2. **Physical and mental health needs**

Inquire whether the person has a history of chronic physical diseases and if he or she is in treatment, since the presence of chronic untreated physical diseases can complicate treatment (National Institute on Drug Abuse, 2012). Inquiries are also directed to whether the person has a history of acute and chronic mental disorders, and whether he or she is being treated for the management of chronic mental health disorders. This dimension includes a brief suicide risk screening of adults and adolescents.

3. **Preparedness for behavior change and motivation to enter treatment**

This dimension explores the person's motivational preparedness for changing substance use behavior and the person's willingness to enter treatment.

4. **Recovery atmosphere (family support and social support)**

This dimension explores whether the person has family support or other significant figure to take part in a treatment; whether any of his/her family members currently use substances, and whether he/she has sought treatment.

It also inquires about risk situations in the family, educational and work context, as appropriate; and coping strategies to deal with them.

Initial Assessment Phases

- The following phases of the initial assessment and diagnostic confirmation can be identified:

1. **Welcome:** Its objective is to generate a context that facilitates the person's active participation throughout the assessment process. This involves providing the person with a comfortable environment, which ensures the private nature of the interview.

- The context of the interview may indicate the use of strategies to foster a collaborative relationship. (Spontaneous consultation, referral from the justice sector, accompanied by family members, among others).

2. **Evaluation:** Its objective is to get the information required to make an initial clinical diagnosis and determine the level of care required. For this, an interview is conducted that takes into account the four dimensions of the evaluation and diagnosis confirmation.

3. **Feedback:** Its objective is to inform the person of the results of the evaluation, recommend his/her participation in the level of care that best suits his/her needs and promote the motivational disposition of the person.
4. **Referral:** Its objective is to carry out a referral to a specific treatment modality according to the requirements assessed, and support the person in that process.

Admission

- Once the person is referred to a treatment modality, according to the results of the Initial Assessment, the next step Initial Evaluation , the next step is to start the admission process to a specific treatment program , for instance to:
  - Outpatient treatment (low or high intensity)
  - Residential treatment
  - Hospitalization (detoxification, suicide risk, others)
  - Each program must have a written admission policy that establishes the characteristics and procedures that must be carried out.

Informed Consent

- Informed consent is essential at each stage of the treatment process, from screening through continuing care.
- Consent is understood as the process in which the therapeutic team provides sufficient and understandable information to the client, which allows them to participate voluntarily and actively in the corresponding treatment.
- It is generally formalized through the signing of a specific document, called **Informed Consent.** It is a process that empowers clients to make informed decisions about health and medical care.
- The consent must establish that during the admission the clients received adequate information regarding:
  - Documentation of the program, including its objectives, treatment methods and standards
  - Obligations and rights, privacy, non-discrimination and limits to confidentiality
  - The role of staff
  - Philosophy of the treatment program
  - Underlying rules on communicating with visitors and people outside the program
  - Administrative aspects, such as the cost of the program and methods of payment

- The voluntary nature of the program must also be discussed, and the informed consent must be documented.
- After signing the informed consent, admission to the treatment program is formalized, which then begins with the Comprehensive Evaluation process.
- The purpose of comprehensive assessment is multifaceted.
- Comprehensive assessment involves determining the extent of the person's need for the following:
  - behavioral health services
  - physical health services
  - housing, education and vocational support
- Are there barriers that need to be addressed for accessing such services and support?
- These needs, once met with support, will promote symptom reduction, the potential for recovery, and the person's ability to live as independently as possible.
- Note that comprehensive assessment needs to be completed BEFORE the start of Treatment. It informs the treatment plan and contributes to more accurate diagnoses.
- Remember that assessment is a process, it is not a one-time event.
- The additional aspects of the purpose of the comprehensive assessment are to:
  - determine the necessity of the level of substance use disorder treatment care provided
  - determine the type of intervention that will be necessary to address the problems
  - evaluate the resources the client can muster to help solve the problem. Typical resources include family support, social support, educational and vocational attainment, and personal qualities such as motivation that the client brings to treatment
  - engage the client in the treatment process
- Comprehensive assessments ideally involve staff from different disciplines (such as a therapist/counselor/social worker and a doctor (especially for assessment of medical needs or pharmacological interventions) and maybe a nurse and social worker. Some countries with health insurance systems also require a formal diagnosis to be made.
- A comprehensive assessment must first be completed before treatment begins.
- A shorter follow-up assessment that asks about the recent past in the different assessment domains can be administered throughout the treatment to measure the person's progress and determine whether changes should be made to the treatment plan as the person progresses through the care system.

- A follow-up assessment is an assessment that is used to assess change in progress in the different domains that were examined at the baseline assessment. For example, in a domain about substance use, a baseline assessment would ask about lifetime substance use and past month substance use before the person entered treatment. The follow- up assessment would then ask about only past month substance use since the person entered treatment. Follow-up assessments are often completed during treatment like 1 or 3 months after entering treatment and then at the end of treatment as well as months after leaving treatment. The results from the timepoints can then be compared to show a pattern of how treatment helped stop substance use or if more help is needed on that domain.
- Any assessment at any stage of care must actively involve the person in their own recovery process.

Comprehensive Assessment Domains

- Understanding the complexity of SUD, of multidimensional origin, determines conducting an assessment that explores and delves into various domains that allow the development of the foundations for defining a person-centered treatment plan.
- It involves a multidisciplinary and comprehensive approach that makes it possible to establish intervention strategies that include the domains in which the problem is expressed, as well as the possibilities and resources for its resolution.
- An in-depth gathering of data and information, typically conducted at the initiation of treatment, needed to understand an individual's or family's needs as a prerequisite for developing a plan of care.
- The comprehensive assessment should be used to assess the severity of problems in functional domains associated with substance use: physical health, employment/ support status, alcohol use, drug use, legal status, family/social functioning and psychiatric symptoms. Once the baseline of severity is established, then follow-up assessment can be completed to see changes in different domains over time.
- On-going process of collaboration.

Comprehensive Assessment Example: Addiction Severity Index (ASI)

- The ASI is probably the most widely used standardised instrument used for clinical assessment and research of Substance Use Disorders.
- In comprehensive assessment ASI can be used to:
    - Assess the problem severity of the clients; and
    - Monitor and quantify changes in the problems commonly associated with substance use, through periodic administration of the tool.

- **The ASI can be used effectively to explore problems within any adult group of individuals who report substance abuse as their major problem. It has 200 items.**
- In 50 minutes to 1 hour, a skilled interviewer can gather information on recent (past 30 days) and lifetime problems in all of the problem areas. Training is required for counselors/ treatment staff to Administer the ASI.
- It only needs 5 minutes to interpret severity ratings.
- Norms are available for:
    - the following treatment groups: alcohol, opiate, cocaine: public, private; inpatient, outpatient.
    - the following subject groups: males, females, people with psychiatric illnesses, people with gambling issues, people who are homeless, those with legal issues, and employee assistance clients.
- The ASI is a semi-structured interview designed to examine the nature and extent of problems in seven areas of life that are often compromised in those who have substance use problems: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status.
- The ASI is a brief semi-structured instrument. A trained counselor can use the instrument as:
    - A guide for substance uses disorder treatment intake;
    - A process of collecting information regarding the nature and severity of problems related to the many life areas affected by substance use disorders
    - An evaluation tool with clinical, program, and research applicability.
- The ASI has been used extensively for treatment planning and outcome evaluation.
- There are three types of scores to be obtained for each of ASI problem areas:
    - Patient Rating scale (0-4)
    - Interviewer Severity Rating (0-9)
    - Confidence Rating (0 or 1)
- Many ASI questions typically have a score of 1 or 0 attached to it. For example, if the patient answers yes, they may score 1; if they answer no, they may score 0.
- It is important to remind everyone of the learning objectives for UTC 5. For module 4 and 5, these include:
    - Describe the process of comprehensive assessment
    - Identify instruments for measuring the different life areas/problems

- Thus, this course is not developed to train anyone on how to competently administer the ASI. There are courses available online for such training.

ASI Versions

- The Teen Addiction Severity Index (T-ASI) is a semi structured interview with 154 items using a multidimensional assessment, 70 ratings in 7 domains. It should be clinician-administered. It is used for periodic evaluation of adolescent substance use. It is particularly useful for adolescents with psychoactive substance use disorders, adolescents with psychiatric disorders and comorbid psychoactive substance use disorders.[15]
- The Addiction Severity Index, Lite version (ASI-Lite) is a shortened version of the Addiction Severity Index (ASI), and it is used to obtain lifetime information about problem behaviors, and in the previous 30 days.[16]
- Addiction Severity Index – Crime (ASI-C) This is a supplement for the ASI legal section that asks more detailed information on legal issues.[17]
- Finally, the WISE course that trains people on how to work with women provides a more female-tailored version of the ASI.
- **Let's look more closely at the T-ASI which serves the adolescent population**
- The domains measured, the life areas examined, and the problems assessed include:
    - Chemical use
    - School status
    - Employment/support
    - Family relationships
    - Peer/social relationships
    - Legal status (involvement with criminal justice program)
    - Psychiatric status, and
    - Contact list for additional information.
- Administration / Completion Time: 30 - 45 minutes for a skilled and trained technician.

Addiction Severity Index - Crime

- Population: Clients within sectors of care, for example: Prison and probation. This is an add-on to the ASI and should not be used as comprehensive assessment alone.
- Administration/ completion Time: interview 20-30 minutes

[15]https://www.emcdda.europa.eu/drugs-library/teen-addiction-severity-index_en
[16]https://adai.uw.edu/instruments/pdf/addiction_severity_index_lite_baseline_followup_5.pdf
[17]https://www.drugsandalcohol.ie/26815/1/Addicition%20Severity%20Index%20-%20crime.pdf

Addiction Severity Index – Lite

- The Addiction Severity Index - Lite version (ASI-Lite) is a shortened version of the Addiction Severity Index (ASI).
- The ASI-Lite contains 22 fewer questions than the ASI, and omits items relating to severity ratings, and a family history grid.
- The ASI Lite also differs from the standard Fifth Edition ASI in two ways:
  1. It contains 22 fewer questions.
  2. Interviewer Severity Ratings are not used.
- Administration Time: 30 minutes

Addiction Severity Index: Flexibility

- The ASI was designed to capture the minimum information necessary to evaluate the nature and severity of patients' treatment problems at treatment admission and at follow-up.
- For this reason, the addition of particular questions and/or additional instruments in the course of evaluating patients is encouraged based on the needs of the patient population being treated. For example,
  - if you are working with patients with injection drug use then adding an HIV risk behavior questionnaire to the comprehensive assessment may be important.
  - if you are serving women or patients with gender and sexual diversity, then adding questions to be serve their needs may be important for good care.
- The seven domains of the ASI that include:
  - medical status-Ideally, a doctor or nurse will also conduct a physical examination as part of evaluating the overall medical status; such examination could include taking biological samples to check for sexually transmitted infections, hepatitis, TB, pregnancy, and physical checking of injecting sites, if the person injects drugs. The exam might also include a check to see whether the patient is already being prescribed medications from other providers, as well as a liaison/consult with the patient's primary healthcare provider. The medical provider will also query the patient to see if they are at immediate risk from their own behaviour or that of others - and if indicated, take immediate mitigating action. This could be protection from abuse by others, mitigation of risk of overdose, etc.
  - employment and support
  - drug use

[18] https://www.emcdda.europa.eu/html.cfm/index4004EN.html
[19] https://www.emcdda.europa.eu/html.cfm/index3572EN.html
[20] https://datashare.nida.nih.gov/instrument/addiction-severity-index-lite

- alcohol use
- legal status
- family/social status
- psychiatric status

Comprehensive Assessment: ASI Domains

ASI Medical Section

- Depending on the types of participants, there could be a need of more medical information to help inform the treatment plan. This includes
  - Client's medical history
  - Lifetime hospitalizations
  - Long-term medical problems
  - Recent physical ailments
  - The Treatnet ASI added several questions to address specific medical conditions.

Optional Questions to be added M12: Hepatitis

M12. Have you ever been tested for hepatitis? ☐
0 = No, 1 = Yes

M12a. If Yes, what was the result? ☐
1 = Hep Negative (not infected)
2 = Hep positive (infected)
3 = Don't Know
• If M12 = No, M12a = "N"

M12b. Would you like help obtaining a Hepatitis test? ☐

- M 12b: Does not necessarily mean that you will provide the hepatitis test on-site; you may make a referral for testing. Remember that there are different forms of hepatitis, A, B and C and it is important to consult with a medical professional about this question before adding it, so you have someone to refer to for testing and treatment to provide if the test is positive or the person indicated that they know they are positive and not receiving treatment.

Optional Questions to be added M13: HIV/AIDS

M13. Have you ever been tested for HIV? ☐
0 = No, 1 = Yes

M12a. If Yes, what was the result? ☐
1 = HIV Negative (not infected)
2 = HIV positive (infected)
3 = Don't Know
• If M13 = No, M13a = "N"

M13b. Would you like help obtaining an HIV test? ☐

- M 13b: Does not necessarily mean that you will provide the test on-site; you may make a referral for testing. Just like hepatitis, a medical provider is needed to guide treatment and referral and one must act if this question is asked and answered "yes" by the client.

Optional Questions to be added M14: Pregnancy

If patient is Male, code all "N" 0=No, 1=Yes, 2=Unsure

M14. Are you currently pregnant? ☐

M14a. If pregnant; do you have prenatal care? ☐

M14b. If unsure; would you like help obtaining a pregnancy test? ☐

• If M14= 0 or 2 (No or Unsure), M14a = N
• If M14= 1 (Yes), M14b = N

- M14b: Does not necessarily mean that you will provide the test on-site; you may make a referral for testing. Again, if this question is asked and answered with a yes response, you must act to ensure follow-up testing and care.

Other Instruments for Medical Status

- The 20-item short form health survey (SF-20) was developed for the Medical Outcomes Study (MOS), a multi-year study of patients with chronic conditions. Note that there is another version the SF-12, however, it is not available for free by its authors, due to a scoring program.
- The six items under physical functioning were selected to assess physical functioning, measuring physical limitations and capacities, mobility, and self-care. What is on the slide is an example of one question in this domain.
- This instrument has questions that touch other domains
    - Role Functioning
    - Social Functioning
    - Mental health

ASI Employment /Support Section

- This section gathers basic information about:
    - Resources a client can record on a job application
    - Schooling/training
    - Current sources and amounts of income
- There are a total of 24 questions in this section that cover the items of what education and training the person completed, if the person has a valid driver's license to help them with employment of get to and from employment, the pattern of employment as well as questions about who supports the person.

ASI Employment /Support Section International Optional Question to be Added

E4a. Are your job options limited by lack of transportation? 0 = No 1 = Yes ☐
Consider adding a question: What other individual, family or social issues limit your job options (Write answer in blank)? _____

- This item was added to the international training and is used to evaluate if transportation problems contribute to employment problems or under-employment. This is a good question to ask. It may also be helpful to ask about other barriers to employment. For example, some people may have care-taking responsibilities for family members that limit their job opportunities.

ASI Employment /Support Section E7 Codes: ISC0 Categories

- International Standard Classification of Occupations
  1. Legislators, officials
  2. Professionals
  3. Technicians / assoc. professionals
  4. Clerks
  5. Service & sales
  6. Skilled agricultural / fish
  7. Craft & trades
  8. Plant / machine operators
  9. Elementary occupations
  10. Armed forces

[21]https://www.rand.org/health-care/surveys_tools/mos/20-item-short-form.html

- These codes are important to have in order to code the type of employment the person has had in the past. It will help with treatment planning for employment for the future.

Comprehensive Assessment: ASI Domains Drug Use and Alcohol Use

List of Commonly Used Drugs

- This section covers the problems with substances, withdrawal, overdoses, and past treatments. When this section is being examined and asked, it is critical to know the common names and types of substances used in your community. Updating this list will be important for your accurate assessment.
- Also note that the order of the substances may need to be revised due to cultural perception of substances. It is best to start with the more common and less stigmatised substances and then move to ethe more sensitive substances.
- Khat is also common in some places in the world and may need to be included on the drug grid.

ASI Drug Section Optional Question to be added D36: Quit without treatment?

D36. How many times have you tried to quit using substances without treatment? ☐☐

- This question may be helpful to add. If so, code the number of times the patient has tried to quit using drugs or alcohol without treatment. This would include any attempt at behavior change with or without support groups.

ASI Drug Section Optional Question to be added D37: Nicotine

D37. Nicotine

Lifetime (years)	Past 30 Days	Route of Admin
☐☐	☐☐	☐

For the accuracy of the responses to this question, it is important to remember nicotine comes in many forms

- E-cigarettes. ...
- Heat-not-burn tobacco products. ...
- Smokeless tobacco. ...
- Hookah. ...
- Cigars/ cigarillos/ little cigars. ...
- Dissolvable products like snuff or snus

ASI Drug Section Optional Question to be Added D39a-e: Motivation questions

D39. Using the patient rating scale, how would you rate your level of agreement with the following statements?

a. I am ready to decrease my drinking. ☐

b. I am ready to decrease my drug use. ☐

c. I believe I can manage my alcohol use. ☐

d. I believe I can manage my drug use. ☐

e. I know I have a drinking or drug problem and I am motivated to work on it! ☐

- Many treatment providers find asking about motivation to be helpful.
- Here is a question used in the substances international ASI. The Intent is to Assess motivation for decreasing drug or alcohol use.
- Note: This is not for assessing motivation for treatment.

Questions for alcohol use on the ASI

- If there are concerns about alcohol misuse and more information is needed, then another measure can be used.
- The SADD questionnaire was derived from the Alcohol Dependence Data (ADD) questionnaire. More narrowly focused than the ADD, the SADD was also intended to be easier and faster to use than previous measures. As reported in the original publication, the SADD was designed to be:

- "(i) suitable for patients seeking help with a drinking problem;
- a measure of present state dependence;
- sensitive across the full range of dependence;
- sensitive to change over time; and
- relatively free of sociocultural influence".[22]

- SADD is for the general adult substance use disorder population, focusing primarily on those who have mild to moderate alcohol use disorder. It is commonly used with male and female clients of addiction treatment programs,
- It is sensitive to inter-client variability at lower levels of dependence and therefore particularly suitable for dual diagnosis patients.
- The SADD is available in pencil-and-paper self-administered or interview format, consists of 15 items, and can be administered in 2-5 minutes.

ASI Legal Section

- This section
  - Examines the nature of the client's personal relationships and marital and living status
  - Determines the extent of any relationship problems with family, friends, or others
  - Documents the client's satisfaction with their current status of relationships
  - As you can see in the questions from Resource Page 4.2, it asks questions such as:
  - What is your present marital status?"
  - "Are you currently married?"
  - If the patient was satisfied during the time living in category selected (even if not current)
  - Asks about who the person spends free time with
  - Asks about problems getting along with
  - Asks about abuse, not just by family or friends
  - It also asks about family history of substance use

[22]Raistrick DS; Dunbar G; Davidson RJ. Development of a questionnaire to measure alcohol dependence. British Journal of Addiction 1983; 78:89-95.

Family/social status

This is a measure used in many different languages. It asks questions around such statements such as:

1. There is a special person who is around when I am in need
2. There is a special person with whom I can share joys and sorrows.
3. My family really tries to help me.
4. I get the emotional help & support I need from my family.

ASI Family/Social Section

- Family APGAR: Frequently utilized as a tool for assessing family function.
- It is a 5-item questionnaire, that measures the family member's satisfaction with each of the five basic components of family function:
    - Adaptation;
    - Partnership;
    - Growth;
    - Affection; and
    - Resolve
- It is widely used in primary care and general medicine settings.[24]

ASI Psychiatric Status Section

- This section is used to determine symptoms of psychological and emotional distress.
- Please be very aware that the intent of this section is not to provide a diagnosis.

[23]Zimet GD, Dahlem NW, Zimet SG, Farley GK. The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment 1988; 52:30-41.
[24]Hiroaki Takenaka, Nobutaro Ban (2016). The most important question in family approach: the potential of the resolve item of the family APGAR in family medicine. Asia Pac Fam Med. 2016; 15: 3. Published online 2016 May 5. doi: 10.1186/s12930-016-0028-9

- In addition, those symptoms associated exclusively with results of ingesting a drug (i.e., hallucinating on acid) or detoxification ("I'm anxious when I detox.") should not be recorded.
- To determine long-term and recent psychological and emotional functioning
- To document current and past history of treatment
- To explore the potential for the need for further evaluation or referral
    - Mood disorders
    - Anxiety disorders
    - Thought disorders, etc.

International Personality Disorder Examination (I.P.D.E)

- Developed within the Joint Program for the Diagnosis and Classification of Mental Disorders of the World Health Organization (WHO) and U.S. National Institutes of Health (NIH) and is based on worldwide field trials.
- Each module (DSM-IV™ and ICD-10) contains an IPDE Screening Questionnaire and the IPDE Semistructured Interview.
- The different descriptive criteria of the disorder are evaluated through a series of questions that refer to 6 areas of life: Job; Self; Relationships; Affections; Reality check; and Impulse control.

Other instruments for types of issues that the ASI does not address

1. Montreal Cognitive Assessment (MoCA)

- Cognitive screening test is designed to assist health professionals in the detection of mild cognitive impairment and Alzheimer's disease
- The MoCA assesses short term memory, visuospatial abilities, executive functions, an attention, concentration and working memory, language, orientation to time and place. ,
- This screening instrument is suitable for screening for cognitive dysfunctions in people with substance use disorder.

[25]https://apps.who.int/iris/bitstream/handle/10665/41912/9780521041669.pdf;sequence=1
[26]https://www.mocatest.org/pdf_files/test/MoCA-Test-English_7_1.pdf
[27]Copersino, M. et al., (2009) Rapid Cognitive Screening of Patients with Substance Use Disorders. Experimental and Clinical Psychopharmacology, Vol. 17, N° 5, 337-344 (DOI: 10.1037/a0017260)

- The MoCA does not comprehensively measure cognition; rather, it provides an estimate of global cognition, assisting clinicians when deciding whether to make referrals for neuropsychological evaluation.

2. Disability Assessment Schedule WHODAS 2.0

- Generic assessment instrument developed by WHO to provide a standardized method for measuring health and disability across cultures, at population level or in clinical practice.
- Measures the level of functioning in six domains of life:
- Cognition – understanding and communicating
- Mobility – moving and getting around
- Self-care – attending to one's hygiene, dressing, eating and staying alone.
- Getting along – interacting with other people.
- Life activities – domestic responsibilities, leisure, work and school.
- Participation – joining in community activities, participating in society.

MODULE 5

THE ADDICTION SEVERITY INDEX

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Summary 358

Content and Timeline	
Activity	***Time***
Introduction to Module 5	10 minutes
Interactive Presentation: Narrative Summary	20 minutes
Small Group Exercise- Developing a SNAP Form	60 minutes
Lunch	*60 minutes*
Interactive Presentation: Narrative Summary (continued)	15 minutes
Small Group Exercise- Writing a Narrative Summary–Kanya	60 minutes
Interactive Presentation: Person Centered Planning	30 minutes
Break	*15 minutes*
Interactive Presentation: SMART	15 minutes
Interactive Presentation: The Mapping Technique	25 minutes
Day 3 Wrap-up	5 minutes
End of Day 3	

Content and Timeline	
Activity	***Time***
Review of Day 3	10 minutes
Small Group Exercise- The Mapping Technique	60 minutes
Interactive Presentation: Interventions	20 minutes
Break	*15 Minutes*
Small Group Exercise- Case Study	30 minutes
Small Group Exercise - Developing a Person-centered Plan	60 minutes
Reading Exercise- Sample Narrative Summary and Sample Treatment Plan	30 minutes
Lunch	*60 minutes*
Small Group Exercise-Treatment Plan	60 minutes
Reflective Exercise	15 minutes

Module 5 Goals and Objectives

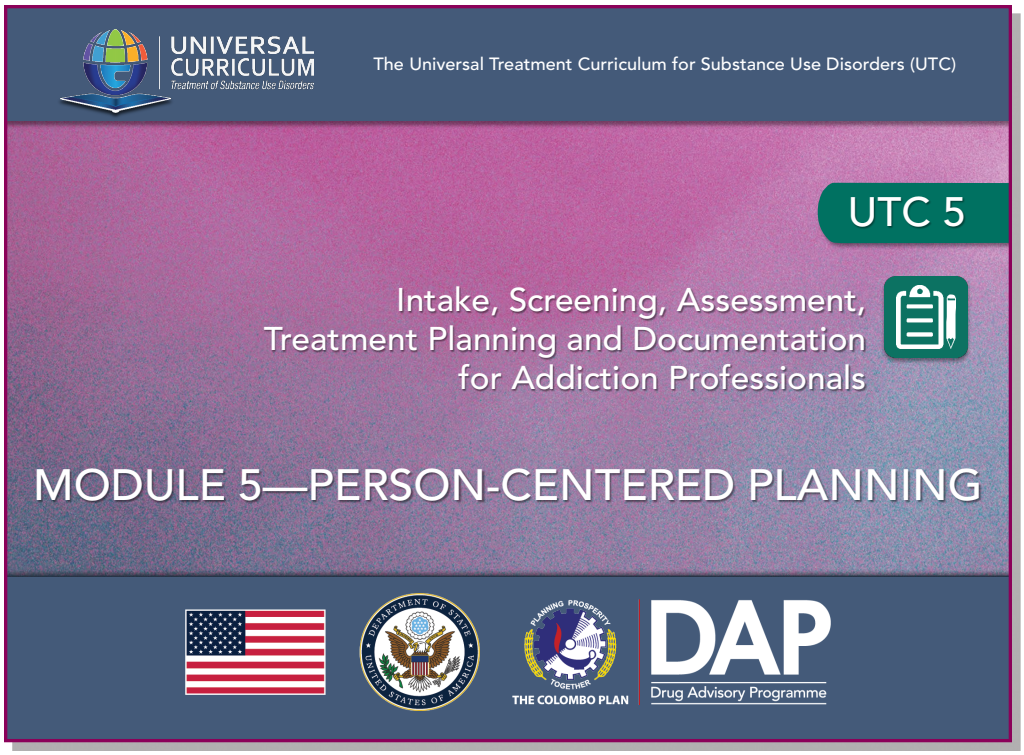
Training goals

- To provide an overview of the process and elements of narrative summaries and person-centered planning;
- To provide an opportunity for participants to practice writing person-centered narrative summaries and treatment plans; and,
- Familiarize participants with the Mapping technique.

Learning objectives

Participants who complete Module 5 will be able to:

- Describe the role of the narrative summary in the planning process
- Describe person-centered planning
- Describe the role of strengths-based assessment in creating a person-centered plan
- Demonstrate beginning ability to use the Mapping Technique
- Create person-centered narrative summaries and plans based on case studies

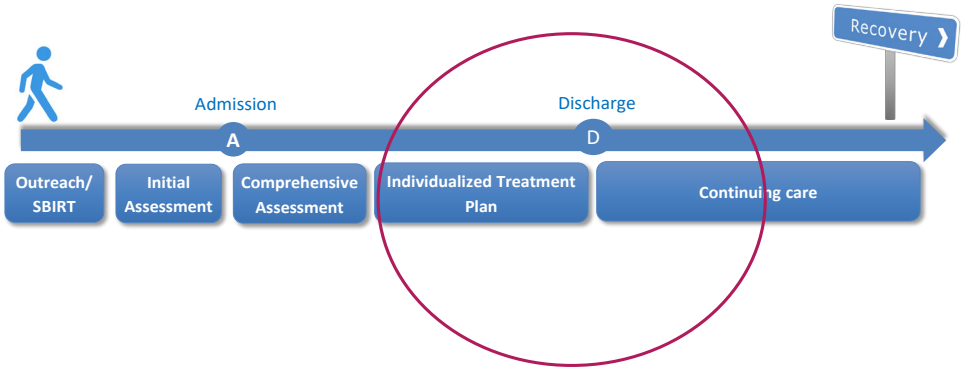

UNIVERSAL CURRICULUM
Treatment of Substance Use Disorders
The Universal Treatment Curriculum for Substance Use Disorders (UTC)
UTC 5
Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals
MODULE 5—PERSON-CENTERED PLANNING
THE COLOMBO PLAN
DAP
Drug Advisory Programme

Module 5 Learning Objectives

- Describe the role of the narrative summary in the planning process
- Describe person-centered planning
- Describe the role of strengths-based assessment in creating a person-centered plan
- Demonstrate beginning ability to use the Mapping Technique
- Create person-centered narrative summaries and plans based on case studies

5.2

Care Pathway



Ref:
- Models of Care for Treatment of Adult Drug Misusers (NTA, 2002) NTA Business Plan 2005/06 (NTA, 2005) NTA Treatment Effectiveness Strategy Briefing 2005–08 (online at www.nta.nhs.uk) Treating Drug Misuse Problems: Evidence of Effectiveness (NTA, 2006)
- Doyle J, Ivanovic J (2010) National Drugs Rehabilitation Framework Document. National Drugs Rehabilitation Implementation Committee. Dublin: Health Services Executive

5.3

Narrative Summary: What It Is and Its Importance

- The bridge between the assessment and the plan
- The term “narrative” is used to emphasize that the summary is based in the counselor's words.
- Direct statements from the person being helped can also be an important aspect
- Often used to justify the level of care being recommended

5.4

Narrative Summary: Elements to Include

- Identity
- Presenting issues in each ASI domain
- Recovery environment
- Strengths, needs, abilities and preferences
- Why treatment is needed at this time
- The Narrative Summary is a record shared with the client and recorded in their treatment chart

- *NOTE that this document may also be called an interpretive summary*

5.5

Narrative Summary – Additional Elements

- Diagnosis and how symptoms are interfering with functioning and life goals; includes health issues
- Central themes, insights, understandings that support effective change efforts

5.6

Gathering Information on SNAP

- The narrative summary will need to describe the person's SNAP, which stands for:
  - Strengths
  - Needs
  - Abilities
  - Preferences

5.7

Example Questions to Ask For SNAP

- STRENGTHS What personal qualities do you have which we can build upon in treatment?
- NEEDS What would help you achieve your goals? Please, check your most important needs. (Prioritize your top three)
- ABILITIES What skills do you possess?
- PREFERENCES How do you want your treatment?

It may help to develop a checklist and then open-ended questions for each area above

5.8

Small Group Exercise- Developing a SNAP Form

Break into four groups

1. STRENGTHS What personal qualities do you have which we can build upon in treatment?

2. NEEDS What would help you achieve your goals?

3. ABILITIES What skills do you possess?

4. PREFERENCES How do you want your treatment?

5.9

Lunch

60 minutes

5.10

Narrative Summary: What It Does

- Weaves the data together in a way that creates a comprehensive understanding of what's going on with the person
- Provides the rationale and justification for the services and interventions the person could be offered

5.11

Language is Important

- Deficit and problem-focused
- Recovery-focused

https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

5.12

Language: Deficit Focus

- Client has low self-esteem
- Client is in denial
- Client is alcohol dependent
- Client is resistant to treatment
- Client is on probation because he is an addict

5.13

Changing Language

- Client has low self-esteem
- Client is in denial
  - Mamun averages 10 negative self-statements daily
  - Antu reports recurring arguments with wife over past 3 months but states that marijuana use is not a problem
- Client is promiscuous
  - Mila participates in unprotected sex four times a week

5.14

Small-Group Exercise: Writing a Narrative Summary–Kanya

- Resource Page 5.2: Kanya's Assessment Summary
- Resource Page 5.3: Narrative Summary Outline
- Assign a spokesperson and someone to record your work
- Write a brief (2- or 3-paragraph) narrative summary for "Kanya"

5.15

Person-Centered Planning

- A collaborative planning process that supports the preferences and recovery of the person receiving services
- Directed by the client or person receiving services in partnership with treatment providers and natural supports
- Intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the person served

5.16

Person-Centered Planning

- Balances person-centered approaches with eligibility criteria to partner with people and support recovery
- Person-directed
- Satisfies documentation requirements

5.17

Critical Aspects of Person-centered Planning

- The inclusion of the person's natural supporters in the care planning process
- Articulation of clearly defined short and long-term personal goals with measurable objectives
- Assignment of responsibility for different tasks and action steps to different members of the care team including the person in recovery
- Use of tools, shared decision-making aids and supported employment, housing, etc.

5.18

Key Practices in Person-Centered Planning

- Shared decision-making: client and provider are partners in all planning activities and meetings
- Considers both the client's action steps and what his/her provider is going to do towards goal attainment
- Client has reasonable control over logistics including invitees, location, and advance notice
- Client is *always* offered a copy of his or her plan

5.19

The plan is a roadmap

7.20

Supporting Recovery: Dimensions

- Health
- Home
- Purpose
- Community

Source: Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's working definition of recovery updated.* Blog entry on March 23, 2012. Retrieved on August 26, 2012, from http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated

5.21

Developing a person-centered treatment plan

- Requesting services
- Assessment
- Understanding holistically who the person is
- Prioritizing
- Goal
- Identifying the person's strengths and the potential barriers
- Objectives
- Services and supports
- Outcome

5.22

Assessment

- A person-centered plan is only as good as the assessment and the assessment is only as good as the relationship that it is built upon

5.23

Context of Planning

- Personal strengths
- Interests and activities
- Living environment
- Employment
- Education and skills
- Financial resources (e.g., income, access to health care)

5.24

Context of Planning

- Lifestyle and health
- Personal choice and control
- Transportation
- Faith and spirituality
- Relationships

5.25

Prioritization

- Where will we start?
  - What are the client's goals?
  - What is important to him or her?
    - To stay out of jail?
    - Reconnect with family?
    - Take care of health issues?

5.26

Client Priorities

- Personal and family values
- Cultural nuances
- Personal concerns and perspectives
- Personal strengths and expertise

5.27

Counselor Priorities

- Basic health and safety
- Reduction of symptoms
- Legal obligations
- Community safety

5.28

Common ground

- Ensure choice over a wide range of options
- Counselors and person receiving services are not failures if a choice does not work out

5.29

Goals

- Life changes as a result of services
- Ideally expressed in person's words
- Positive language
- Consistent with desire for self-determination; may be influenced by culture and tradition

5.30

Goal: "I want to reunite with my family."

- Objective #1: Within one month, Rajib will demonstrate ability to use 3 anger management skills
- Objective #2: Within 60 days Rajib will have a minimum of one successful visit with his children, as reported by his wife

5.31

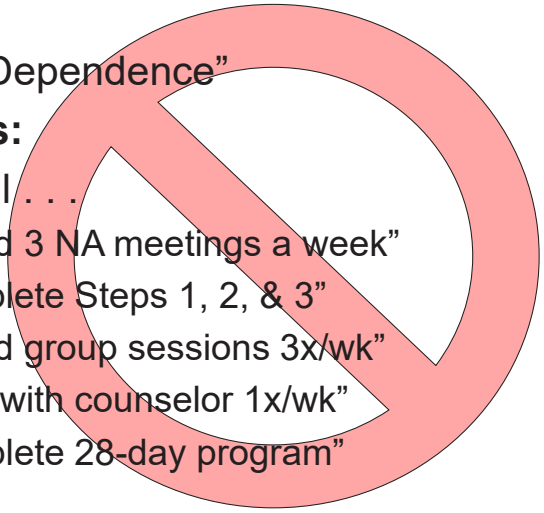
And Not Just...

Problem:

- "Heroin Dependence"

Objectives:

- Client will . . .
  1. "Attend 3 NA meetings a week"
  2. "Complete Steps 1, 2, & 3"
  3. "Attend group sessions 3x/wk"
  4. "Meet with counselor 1x/wk"
  5. "Complete 28-day program"



5.32

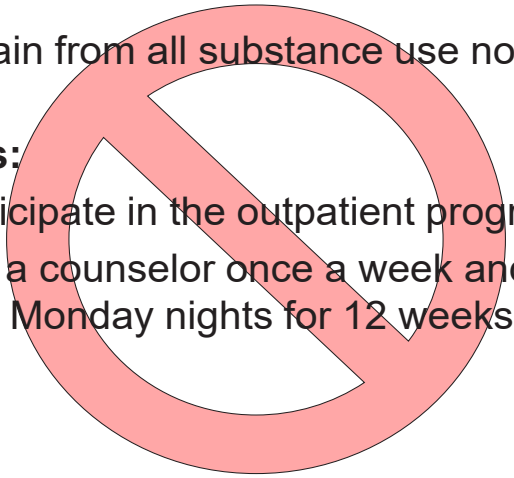
And Not Just...

Goal:

- "Will refrain from all substance use now and in the future"

Objectives:

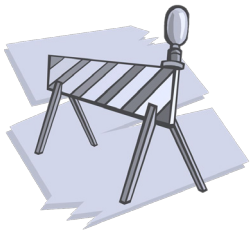
- "Will participate in the outpatient program"
- "Will see a counselor once a week and attend group on Monday nights for 12 weeks"



5.33

Barriers to Goals

- Challenges as a result of a substance use or mental disorder:
  - Challenges in activities of daily living
  - Threats to basic health and safety
  - Need for practical assistance or supports



5.34

Barriers to Goals (continued)

- What's getting in the way?
  - Need for skills development
  - Problems in behavior
  - Intrusive symptoms
  - Lack of resources

5.35

Dropping Out of Treatment Before Completion: Hypotheses

- Prefers alternative coping strategies
- Ambivalent about staying in treatment
- Does not recognize that they are experiencing symptoms/barriers to their goals
- Interferes with important experiences
- Family objects
- Culturally inappropriate method for addressing experience
- Treatment may not be client-centered.
- Treatment services / staff are not adequate

5.36

BREAK

15 minutes

5.37

Objectives: SMART

Setting specific, measurable, achievable, relevant, and time-bound (SMART) objectives is a good way to plan the steps to reach the client's goals. Helps you put ideas into action. Setting SMART objectives lets you know that you are accomplishing what you set out to achieve

5.38

Objectives—Wording

- Specifies expected changes in behavior, function or status:
  - "Within X days the individual/family will…"
  - "As a result of services and supports, Mr. X will…, as evidenced by…."

5.39

Objectives—Measurable

- Client will decrease arguments with wife:
  - Within 30 days, Zahid will demonstrate to counselor three new communication skills
  - Zahid will participate in a minimum of one conflict resolution group each week for the next 60 days

5.40

Objectives—Measureable (continued)

- Client will decrease frequency and intensity of substance use:
  - Within 30 days, Nipu will identify to the counselor the time of the day that is easiest to give up cannabis and practice being cannabis free at that time.
  - Nipu will be substance-free for 6 months as evidenced by negative urine drug tests administered randomly (action)

5.41

Objectives—Barriers

- Client will adhere to methadone dosing schedule
- What is the barrier?
  - Family stigma?
  - Within 30 days, Refat will share with his family the information on the benefits of taking methadone for himself and his family

5.42

Objectives—Barriers

- Client will adhere to methadone dosing schedule
- What is the barrier?
  - If he takes methadone reliably what will change??
  - Within 30 days, Refat will experience fewer heroin cravings as evidenced by self-report in daily self-monitoring diary.

5.43

Services Are Not Objectives

- Mithee will demonstrate increased engagement in services as evidenced by her attendance at 75 percent of her appointments with her counselor over the next 3 months

NOT

- Client will consistently attend all appointments with her counselor over next 3 months.

5.44

Objectives—Focused

- A maximum of two or three objectives per goal is recommended to create focus and reduce the chances of feeling overwhelmed.

5.45

Objectives—Process-Oriented

- A process-oriented objective can be used if it is the most ambitious step the person can take based on functioning or severity of illness:
  - Within 2 weeks, Wei will contact 2 potential employers.
  - Within 1 month, Wei will complete 3 job applications.

5.46

Objectives—Outcome-Oriented

Short-term, outcome-oriented objectives are ideal.

- Goal: Wei wants to get a job
  - Outcome-oriented objective: Within 1 month, Wei will complete 4 job interviews

5.47

Objectives—Guidelines

- Start where the person is
- Be as ambitious as possible, but ensure objectives are achievable
- Increase expectations over time to support person's progress

5.48

Objectives—Increasing Expectations

- Client will stop using all substances
  - Borna will complete an intake interview for SUD treatment within 2 weeks
  - Borna will create a plan that supports her in obtaining an NA sponsor within 30 days
  - Borna will remain drug free as evidenced by negative urine drug tests over the next 90 days

5.49

Objectives—Increasing Expectations (continued)

- Client will improve parenting skills
  - Borna will identify 3 preferred relaxation skills within 2 weeks in her session with her counselor
  - Borna will demonstrate her ability to use 3 conflict resolution skills within 1 month in her conflict resolution group
  - Borna will have 3 non-confrontational conversations with her son within 2 months as evidenced by her sister's report

5.50

Assessing the Treatment Goals

It is important to:

- Review treatment plans on a regular basis
- Assess if the goals are adequate and determine if there is a need to reformulate them
- Assess if treatment interventions (activities) have been effective and replace them with others if these interventions were ineffective
- In the course of treatment, unforeseen situations can occur that may require reformulating the goals or formulating new ones

5.51

Assessing the Treatment Goals

- It is advisable to look into the level or degree of goal attainment that the person served considers acceptable or successful, for which “scaling questions" or "extreme scales" can be used.
- It is a technique that prompts the persons served to think in terms of a Visual Analogue Scale (VAS), which enquire into the persons’ own perception of their behavioral changes.

5.52

Assessing the Treatment Goals

In general, a scale of "1 to 10" is used, with 1 representing the behavior before the person had sought therapeutic help or before entering treatment, and 10 the changes he/she hopes to achieve (the indicators of success). For example:

The counselor asks:

On a scale from 1 to 10, with 1 meaning “I have not achieved _____” and 10 meaning “I have achieved _____”,

What number would you say you're in today?

1 2 3 4 5 6 7 8 9 10

5.53

Assessing the Treatment Goals

The person can compare his/her score in successive VAS, which can facilitate the person’s reflection/recognition of the actions that have allowed him/her to advance in his/her route or explain the scores’ setback

5.54

Flexible Planning

- Treatment plans need to be living, breathing documents
- They must change over time to remain motivating and relevant

5.55

The Mapping Technique

- Person-Centered Treatment Plan requires collaborative work between the counselor and the client
- Use of Mapping Techniques facilitate client- counselor collaboration and assist clients in articulating and claiming ownership of the treatment plan
- Mapping Techniques use graphical representations (or mapping) of information, ideas or suggestions to help clients analyze problems and situations

5.56

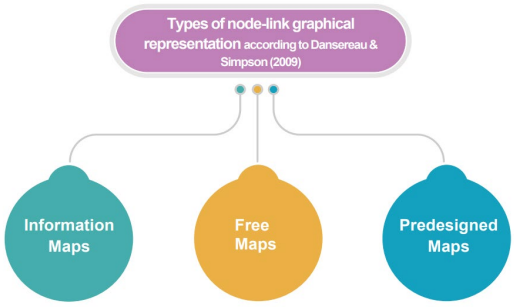
The Mapping Technique

- The Mapping Techniques are effective, affordable and evidence-based technical tools and resources.
- Controlled clinical studies have demonstrated the effectiveness of the mapping technique in the treatment of adults and adolescents

5.57

The Mapping Technique

- Mapping is a cognitive tool that helps organize information and ideas spatially
- Types of maps:

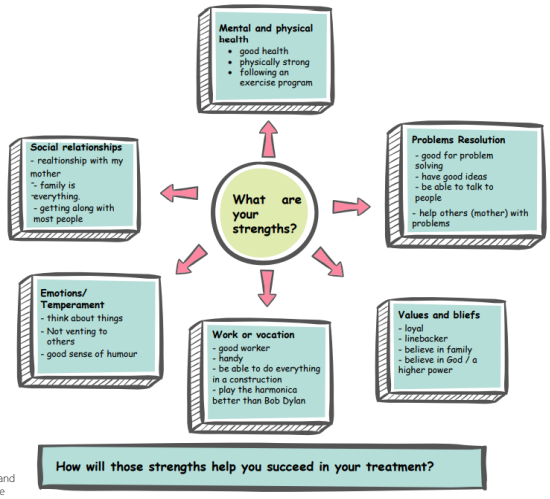

Types of node-link graphical representation according to Dansereau & Simpson (2009)
Information Maps
Free Maps
Predesigned Maps

This document was prepared by the SENDA Treatment and Rehabilitation Area (2018), based on an adaptation of the Mapping Guidelines of the Institute of Behavioral Research at Texas Christian University (TCU).

5.58

Information or Knowledge Maps

Knowledge maps are created to communicate information about specific topics:


Mental and physical health
• good health
• physically strong
• following an exercise program
Social relationships
- realtionship with my mother
- family is everything.
- getting along with most people
What are your strengths?
Problems Resolution
- good for problem solving
- have good ideas
- be able to talk to people
- help others (mother) with problems
Emotions/ Temperament
- think about things
- Not venting to others
- good sense of humour
Work or vocation
- good worker
- handy
- be able to do everything in a construction
- play the harmonica better than Bob Dylan
Values and bliefs
- loyal
- linebacker
- believe in family
- believe in God / a higher power
How will those strengths help you succeed in your treatment?

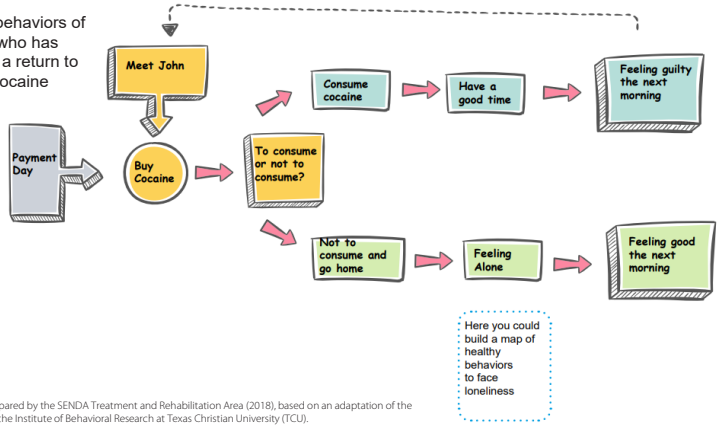
This document was prepared by the SENDA Treatment and Rehabilitation Area (2018), based on an adaptation of the Mapping Guidelines of the Institute of Behavioral Research at Texas Christian University (TCU).

5.59

Free Maps

Free maps are built on a blank sheet and seek to represent in a diagram the ideas that are being discussed:

Free map of behaviors of a person who has experienced a return to use on cocaine

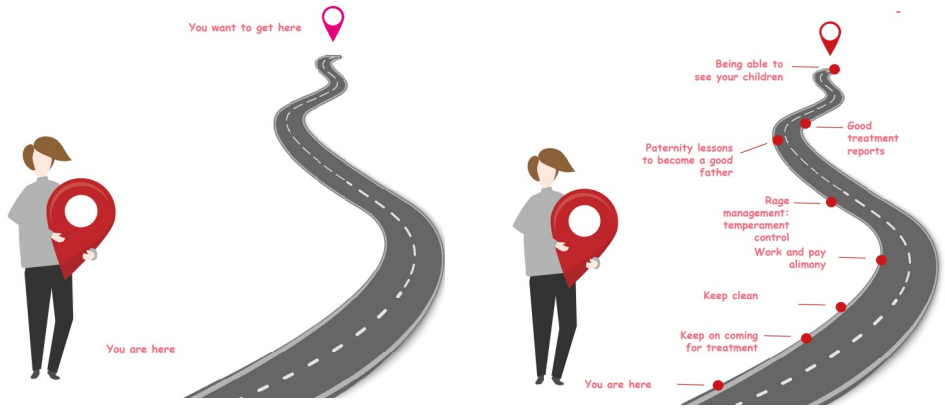

Meet John
Payment Day
Buy Cocaine
To consume or not to consume?
Consume cocaine
Have a good time
Feeling guilty the next morning
Not to consume and go home
Feeling Alone
Feeling good the next morning
Here you could build a map of healthy behaviors to face loneliness

This document was prepared by the SENDA Treatment and Rehabilitation Area (2018), based on an adaptation of the Mapping Guidelines of the Institute of Behavioral Research at Texas Christian University (TCU).

5.60

Predesigned or Guide Maps

Guide maps consist of a template with blanks to be completed by the person being treated.


You want to get here
You are here
Being able to see your children
Good treatment reports
Paternity lessons to become a good father
Rage management: temperament control
Work and pay alimony
Keep clean
Keep on coming for treatment
You are here

This document was prepared by the SENDA Treatment and Rehabilitation Area (2018), based on an adaptation of the Mapping Guidelines of the Institute of Behavioral Research at Texas Christian University (TCU).

5.61

The Mapping Technique

Mapping technique helps the client to:

- Identify salient goals to work on as part of treatment
- Narrow the treatment goals down to clear, specific, and practical plans
- Have a conversation on specific steps he/ she would like to take
- Focus on the personal strengths he/she brings to deal with identified problems

5.62

The Mapping Technique

The maps developed by the client and the therapist can be:

- Handed out as a reminder of the session or as homework assignments between sessions
- Reintroduced by therapists in the sessions to assess changes and progress
- Useful for continuity of care

5.63

The Mapping Technique

Use of the Mapping Technique can:

- Create a sense of collaboration, by withdrawing the attention from the client and placing it on a graphical representation of the topic that is being addressed
- Reduce anxiety in clients who feel uncomfortable with eye contact
- Help client and therapist generate more ideas (in comparison to sessions centered on conversation only)

5.64

The Mapping Technique

The manual contains tools and techniques to improve the assessment and carry out a recovery plan for people with Substance Use Disorders

5.65

The Mapping Technique

Goal planner

Problem area	Satisfaction out of 10	What would have to change to increase my score by 2?	Rank
Health (physical and mental)			
Social life and friends			
Relationships (partner or family)			
Housing			
Job / education			
Money			
Exercise			
Legal and crime			
Drug and / or alcohol use			

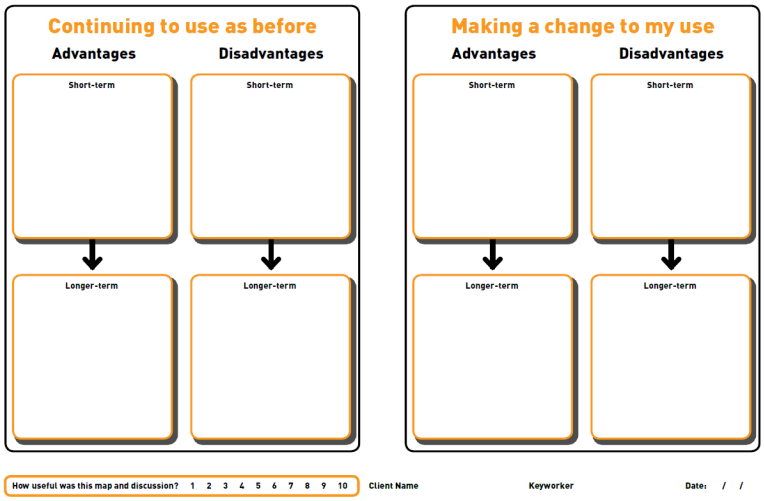
How useful was this map and discussion? 1 2 3 4 5 6 7 8 9 10 Client Name Keyworker Date: / /

33

Day E (2013) Routes to Recovery via the Community, Public Health England, London.

5.66

The Mapping Technique

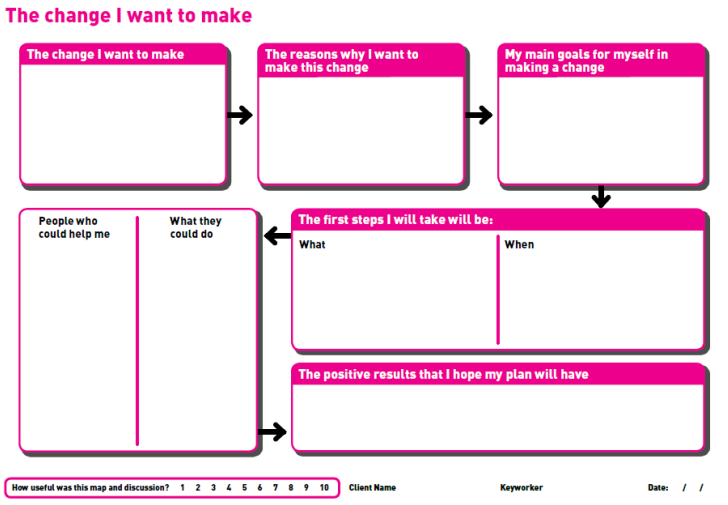


45

5.67

Day E (2013) Routes to Recovery via the Community, Public Health England, London.

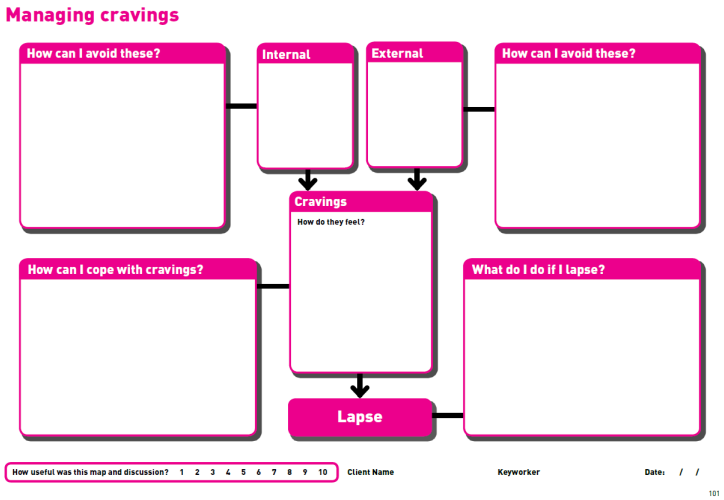
The Mapping Technique


The change I want to make
The change I want to make
The reasons why I want to make this change
My main goals for myself in making a change
People who could help me
What they could do
The first steps I will take will be:
What
When
The positive results that I hope my plan will have
How useful was this map and discussion? 1 2 3 4 5 6 7 8 9 10
Client Name
Keyworker
Date: / /
103

5.68

Day E (2013) Routes to Recovery via the Community, Public Health England, London.

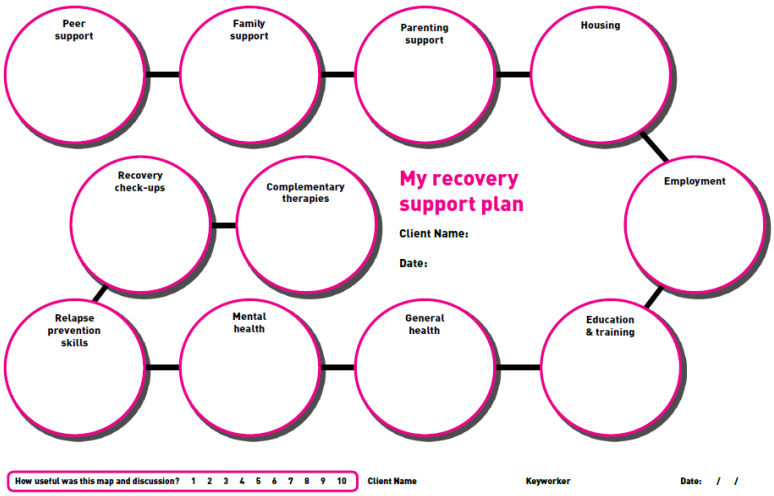
The Mapping Technique



5.69

Day E (2013) Routes to Recovery via the Community, Public Health England, London.

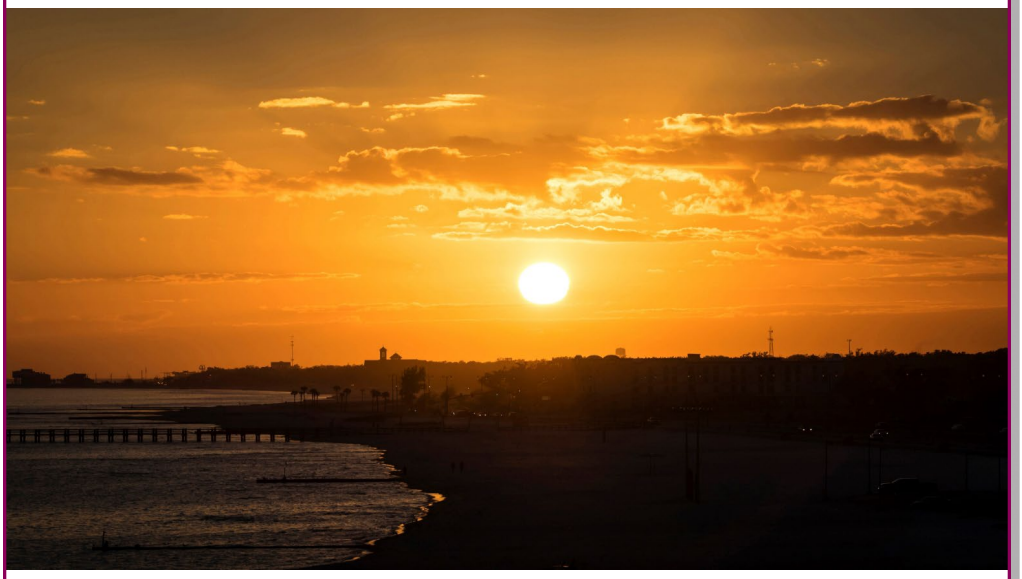
The Mapping Technique



5.70

Day E (2013) Routes to Recovery via the Community, Public Health England, London.

Day 3 Wrap-up



5.71

UNIVERSAL CURRICULUM
Treatment of Substance Use Disorders

The Universal Treatment Curriculum for Substance Use Disorders (UTC)

UTC 5

Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals

MODULE 5—PERSON-CENTERED PLANNING

THE COLOMBO PLAN

DAP
Drug Advisory Programme

Small group exercise: The Mapping Technique

- Move into small groups
- Use Maria's case "Preventing a return to use" found on resource page 5.1
- From the information provided, create a Free Map on a flip chart based on the intervention developed by the counselor
- Make a presentation on the map created by your group to the entire class

5.73

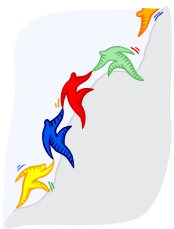
Interventions (Services)

- A treatment plan needs to indicate what interventions will be provided in support of the client's goals
- *Interventions* are planned services or strategies or methodologies

5.74

Interventions (Services) (continued)

- Actions by staff members, the client, and the client's family, peers, and natural supports that:
  - Respect client's choice and preference
  - Are specific to the stage of change and recovery
  - Describe the reason for the intervention
  - Are specific to goals and objectives



5.75

Interventions

- Clarifies who does what
- Includes a task for:
  - The client
  - A family member
  - Other natural supports

5.76

Interventions–Five Elements

- Counselor's or other service provider's name and role
- Specific service provided
- How often, how much time, and for how long
- Location of services
- Purpose of the service or action

5.77

BREAK

15 minutes

5.78

Person-Centered Planning: Continuing Care

"Following treatment for drug use disorders, most patients require some degree of long-term recovery management, whose intensity reflects the individual patient's needs".

Therefore, the treatment plan must be readjusted, redesigned with the aim of supporting the maintenance of the therapeutic changes achieved and promoting their social integration, incorporating new support strategies.

World Health Organization and United Nations Office on Drugs and Crime, 2020, International standards for the treatment of drug use disorders

5.79

Person-Centered Planning: Continuing Care

Treatment plans in recovery-oriented care consider all aspects of care in which professionals from different fields participate. These professionals must function as a multidisciplinary team and also include supportive friends and family.

The plan should include personal strategies to prevent a return to drug or polysubstance use (with a high risk of overdose); maintain housing; secure or hold employment; establish or sustain positive social networks; and re-integrate into the community. Plans should also include rapid access back to treatment if the patient returns to use.

World Health Organization and United Nations Office on Drugs and Crime, 2020, International standards for the treatment of drug use disorders

5.80

Case study –Chadni

Chadni came to the SUD treatment clinic asking for help with her cocaine use. Her son and daughter-in-law are tired of her demanding behavior when she is craving and will no longer spend time with her. She is agreeing to treatment and came in for an intake assessment. In her assessment she reports periods of sadness and tiredness dating back to before she started using cocaine.

5.81

Small group exercise: Person-Centered Planning with Chadni

- Move into small groups.
- Use treatment plan form provided
- Establish at least 3 goals with:
- Objective/s for each goal (what will Chandi do and what will counselor do)
- List strengths and potential barriers
- What treatment intervention will counselor and client agree to?

5.82

Outcomes

- The outcome of successful person-centered treatment planning is that people develop the skills and knowledge they need to support their *own* recovery and wellness

5.83

Small-Group Exercise: Developing a Person-Centered Treatment Plan

- Review Resource Page 5.2: Kanya's Assessment Summary
- Assign a spokesperson and someone to record your work
- Develop a plan that has two goals
- For each goal, list two objectives
- For each objective, identify:
  - Kanya's potential strengths and barriers
  - A set of interventions.

5.84

Reading Exercise: Sample Narrative Summary and Treatment Plan - Kanya

- Sample narrative summary – Kanya
- Kanya – Three possible treatment plan excerpts

5.85

LUNCH

60 minutes

5.86

Small-Group Exercise: Treatment Plan

- Resource Page 5.7: Madhukar's Assessment Information
- Assign a spokesperson and someone to record your work
- Write a brief (1- or 2-paragraph) narrative summary for Madhukar
- Develop a treatment plan for Madhukar:
  - 2 goals, each with 2 objectives
  - Strengths and potential barriers
  - Interventions for each objective

5.87

Reflective Exercise

- Take 15 minutes to write about key learnings regarding person-centered planning

5.88

Resource Page 5.1: Maria's case "Preventing a return to substance use"

Maria was recently released from prison, where she served a brief sentence for using and selling crack. She is required to participate in drug abuse treatment.

She has narrated to the therapist how difficult it has been for her to remain abstinent, and that she is bored at the job where she was hired after her release. She's able to perceive some good things about her current situation. She has been able to pay off some debts, feels good living with her family, and has recently established a loving relationship with a young man who does not use drugs.

However, the counselor perceives that she is at great risk of relapsing into crack use, and decides to carry out an intervention with the help of a map.

The counselor builds a Free Map as she talks with the user (client).

The session

COUNSELOR: Maria, what will happen if you start using crack again? Think about it, try to imagine it. I will sit next to you and as I listen to you I will draw on this sheet of paper what you are saying to me, so that we can review it together

MARIA: (Long pause) With my luck, I'll get imprisoned again. I hate that place. It's the worst there can be. And what I have achieved with my family, forget it!

COUNSELOR: (Drawing) Then you are sure that if you use again you will go to jail, and that would affect your family relationships.

MARIA: Yes.

COUNSELOR: Is jail a bad dream?

MARIA: A nightmare. It's a stinky nightmare. You cannot sleep, the bed is hard and there is a lot of noise. They don't give you clean clothes. And I'll be a caged bird again. People don't want to hire you for a job and you feel like you're worth nothing.

COUNSELOR: Prison is uncomfortable, it is dehumanizing and stigmatizing, you and the other prisoners are inferior. Is that all jail means to you?

MARIA: It hurts you. A lot of pain.

COUNSELOR: Yes, it is a bad experience to be imprisoned.

MARIA: (Looking at the map) Yes.

COUNSELOR: (After a while, in which Maria has been silent) And your family relationships? If you use crack again, will that affect your family's feelings for you?

MARIA: They are afraid of me. They fear me because they think I can hit someone.

COUNSELOR: Have you hit someone in your family?

MARIA: Yes, my sister. I hit her hard. But I told her that I was sorry. It was just the need to take the drug. It won't happen again, even if I use again. But my family doesn't trust me. They resent me when I live in the house and do drugs. They treat me badly. So I really make them feel bad. I resent them.

MARIA: (Looking at the map) I said resentment towards them, add it.

COUNSELOR: Okay. When they get mad at you and you resent them, what do you think happens?

MARIA: I don't know. Oh yeah, I make them feel really bad. (Maria notices the map and says) Things are getting worse.

COUNSELOR: Your anger makes things worse, right? And then everyone gets mad (drawing lines on the map). How do you feel about all this?

MARIA: It makes me feel really bad.

COUNSELOR: So if you use again you will have pain, a lot of pain, because of the things that happen in prison and with your relationship with your family. Right?

MARIA: Yes, it's bad.

COUNSELOR: When you feel pain, when you feel hurt, what are you most likely to do?

MARIA: Before I was clean, later I got involved with drugs, and I would not mind that everything was the same again. But pain is something different, it makes me want to change.

COUNSELOR: So here is an option; you have to choose. You can choose to manage your pain by using crack again or choose to change the way you live and seek something better.

MARIA: Yes, but I already chose. I will not use again. I don't want things to be the way they were before.

COUNSELOR: But you still feel some pain, right? Life is not perfect. The pain of living, which you think is not fair, could lead you to use again ...

MARIA: No. I will not use again (looking at the map). No way.

COUNSELOR: I think it's a very good idea not to fall into this vicious cycle again.

Resource Page 5.2: Kanya's Assessment Summary

Identifying Information, Presenting Concerns, and Living Situation

Kanya is a 25-year-old female who has experienced symptoms of trauma, depression, and substance use disorders (SUDs) (marijuana and heroin). She and her daughter live with Kanya's sister. Kanya's sister reports that Kanya is unable to properly take care of her daughter. Recently, the sister was out of town for 2 days to attend a funeral, leaving the daughter in Kanya's care. When the sister returned, Kanya was passed out and she had no idea where the daughter was. The daughter was at a neighbor's home, but Kanya later admitted that she had left the daughter alone the night before to go out and look for marijuana. The daughter has been getting into some trouble, and Kanya is having difficulty setting appropriate limits with her. Kanya has had frequent arguments with the daughter, including, on one occasion, an argument during which she slapped her daughter across the face when Kanya was high.

Kanya has been unable to find a source of employment other than sex work. Kanya's sister is very concerned about Kanya's substance use and her difficulties with her daughter.

Kanya makes it clear that she wants to work toward taking full responsibility for her daughter and bringing in some income, but she is going to need help planning for a new job. Her sister is willing to let Kanya continue to live with her provided that she sees Kanya is taking steps to get her life back on track. Kanya has agreed to SUD treatment and wants to develop adequate parenting skills and get a job.

Strengths, Interests, and Goals

Kanya is motivated to make progress in her recovery and take on the responsibility of caring for and supporting her child. She recognizes the need to replace her substance use with healthy coping strategies. She loves her daughter, values her role as a mother and relies on her sister's support to provide for her daughter as she struggles to manage symptoms of trauma, depression, and SUDs. She has a strong desire to improve her relationship with her daughter and wants to be a better role model for her. Kanya finds relief in weaving and sewing. She has occasionally sold her work. She sees this as an important part of her self-care and recovery, and she would like assistance pursuing handicraft-related employment.

Family and Social Support History

Kanya is the fifth of six children. Her mother reportedly suffered from an undiagnosed mental illness and died when Kanya was 6 years old. She was raised by her paternal grandmother until the age of 8 when the grandmother passed away suddenly. Kanya's father frequently criticized her and beat her. A neighbor raped her when she was 12, and she became pregnant. Kanya ran away from home at 12, and with the help of her older sister, she re-located to her sister's home.

Mental Health Concerns, Treatment History, and Medication

Kanya reports symptoms of trauma and depression. She has frequent nightmares that disrupt her sleep, and she is sometimes too sad and tired to get out of bed in the morning.

In the past, this has made it difficult for her to take care of her daughter. She reports feeling overwhelmed and irritable. She reports fighting a lot, especially with her daughter. Kanya has limited coping skills to manage her symptoms.

She has no history of treatment or medications before this treatment admission.

Substance Use

Kanya has had periods where she has used marijuana and heroin. She has used only marijuana for the past 5 years. At times, her marijuana use has led to significant impairment of judgment (e.g., she has left her daughter unattended) and behavior problems (e.g., she hit her boyfriend in 2007; slapped her daughter). Kanya views her marijuana use as her best means to "escape" when she can't handle the stress of her life. She has tried to cut back on her use over the past 2 months but still smokes up to 3 times a day, 3 days a week. She reports that she has intense cravings and is worried that she won't be able to stop using altogether and find other ways to manage her stress.

Health Summary

Kanya reports feeling fatigued most of the time and has not had a recent physical exam. She is at risk for sexually transmitted diseases and HIV. She should also be evaluated for conditions that may be contributing to her sleep problems.

Trauma History

Kanya experienced prolonged emotional and physical abuse by her father. Her only child, a daughter, is the product of a rape by a neighbor when Kanya was 12.

Risk/Safety

Kanya does not report any suicidal or homicidal ideation and is not currently considered to be a risk to herself or others. However, in the past when she was experiencing intense symptoms of depression and trauma, Kanya became verbally aggressive toward others, has slapped her daughter, and on one occasion, hit a boyfriend.

Employment and Education

Kanya completed primary school. She works, intermittently, as a sex worker and has sold a few of her own handicrafts.

Legal Status and Legal History

None.

Community Living Skills

Substance use and symptoms of trauma and depression frequently leave Kanya feeling too tired to attend to her own personal self-care and her child. It is hard for Kanya to manage more difficult tasks such as obtaining stable employment. The ability to parent her child well is important to Kanya and is one of the community living skills she is seeking to improve. She would benefit from counseling and skills building to learn how to effectively communicate with her child and how to manage emotionally charged situations without verbal or physical aggression.

Resource Page 5.3: Narrative Summary Outline

The narrative summary is the bridge between assessment information and the treatment plan. It blends the findings and opinions of the interviewers and the preferences of the individual into a concise synthesis.

Identity (consider age, culture, spirituality/religious affiliation, sexual orientation, etc.)

Explanation of Illness/Presenting Issues (why is the person here? why now?)

Strengths, Preferences, and Priorities (personal talents/interests/coping skills as well as natural supports and community connections)

Stage of Change

Diagnosis (with rationale, as appropriate, and a focus on how symptoms are interfering with functioning and life goals. Include consideration of significant health issues)

Hypotheses (central themes, insights, understandings, etc., that set the stage for effective change efforts)

Resource Page 5.4: Treatment Plan Format

Goal #1:

Client Strengths:

Potential Barriers/Assessed Needs:

Goal #1, Objective 1:

Objective 1 Interventions and Action Steps:

Goal #2:

Client Strengths:

Potential Barriers/Assessed Needs:

Goal #2, Objective 1:

Objective 1 Interventions and Action Steps:

Resource Page 5.5: Sample Narrative Summary—Kanya

History, Demographics, and Presenting Issue

Kanya is a 25-year-old woman and mother of a 12-year-old daughter. She has, at times through the years, relied on the support of her sister to provide for her daughter as she struggled to manage symptoms of trauma, depression, and substance use (marijuana dependence, with physiological withdrawal; opioid abuse, in full remission). Her sister has been a stable and supportive influence. Kanya was recently brought to the addiction treatment program by her sister because of Kanya's inability to care for herself and parent her daughter. In particular, Kanya was having increasing difficulty relating to her 12-year-old daughter and managing her behavior, and that inability has led to frequent intense arguments. This pattern may have been partly the result of irritability associated with depression and Kanya's marijuana use; however, the daughter is currently at the same age that Kanya was when she became pregnant with her daughter as a result of rape by a neighbor. It is possible that this reminder is triggering an increase in trauma-related stress and symptoms and making it particularly difficult for Kanya to effectively parent her daughter.

Kanya is feeling overwhelmed and distressed by her situation; she is hopeful regarding your program and what it has to offer. She has made it clear that her priority goal is to work toward appropriately parenting her daughter, and she is in the preparation stage of change and is motivated to work with your team of staff members to develop the stability and skills needed to be the best mother she can be.

Summary of Assessed Needs

Kanya has needs in multiple areas that may need to be addressed in future plans. The needs that currently interfere with her primary goal of parenting her daughter include:

- Family relationships: Through the years, Kanya has had difficulty independently parenting her daughter. Most recently, she has been having frequent verbal (and one physical) fight with her daughter.
- Symptom management: Kanya has experienced very traumatic events in her life and the symptoms of her trauma disorder have led her to frequent marijuana use (she's cut back to about three times a day, 3 days a week) and heroin use (not in the past 5 years) to cope with distressing symptoms. In addition, she frequently has trouble sleeping (typically never sleeping through the night without being wakened by nightmares). She sees getting and staying off marijuana and relief from her nightmares as priority areas to address in her plan, given the impact these issues have on her functioning.
- Employment: Kanya has historically had difficulty getting stable employment. This is the result symptoms of trauma, depression, feeling overwhelmed, and her substance use. In the absence of stable employment, Kanya has worked intermittently as a sex worker. She identifies finding a job as a priority area in which she wants to develop skills because she wants to be more responsible and a better role model for her daughter.

Kanya has a number of strengths and interests that she can draw on to overcome the difficulties she has experienced to achieve her goals. She is a devoted mother who tries to make sure that her daughter is taken care of. She places a high value on support from her sister and has benefited from the ongoing relationship with her sister. She demonstrates significant resilience having survived multiple traumas and losses in her life. She is highly creative and has found relief in sewing and weaving.

Resource Page 5.6: Kanya—Three Possible Treatment Plan Excerpts

Goal #1

"I want to be able to take care of my daughter."

Strengths

Loves her daughter; recognizes need for skill development to manage emotionally charged situations; sister is supportive.

Barriers/Assessed Needs

Frequent arguments with daughter; one instance of slapping daughter; in need of skill development in communication, parenting, and conflict resolution; feeling overwhelmed, stressed, irritable, and tired and experiencing trauma triggers, all of which exacerbate parenting difficulties.

Objective

Kanya will have a minimum of three successful conversations with her daughter by June 14, 2012, as evidenced by sister's report that Kanya resolved three emotionally charged situations with her daughter without verbal or physical escalation.

Interventions and Action Steps

- Rupa Costa, Clinician, will meet with Kanya once weekly for the next 3 months to assist her in identifying and managing trauma symptoms that affect her parenting and trigger her angry reactions with her daughter.
- Mita Sinha, Addiction Counselor, will provide twice monthly anger management group sessions for 3 months to teach Kanya conflict resolution and positive coping strategies to manage stressful situations that arise with her daughter.
- Megla Dey, Community Liaison, will meet with Kanya twice over the next 2 weeks to help Kanya identify and access parenting-support groups in the community so she can develop a healthy peer network with whom to share her parenting concerns and receive support. In addition, the Community Liaison will assist Kanya in learning about events/activities in the local community that Kanya and her daughter could attend together.
- Within 2 weeks, Kanya will develop a list of preferred activities she'd like to engage in with her daughter to help increase the amount of enjoyable time they spend together.
- Kanya's sister will participate in the treatment center's family psychoeducation program to receive education about the relationship between substance use, trauma, and depression.

Goal #2

"I just want to sleep through the night without using marijuana."

Strengths

In a safe, stable living situation; beginning to understand the relationship between substance use, trauma, depression, and sleep disturbance; positive relationship with addiction counselor, who offers healthy relaxation group.

Barriers

Vivid nightmares wake Kanya up repeatedly throughout the night; she has not slept through the night in months; tends to resort to use of marijuana to relax, sleep, and relieve distress caused by nightmares.

Objective

By July 14, 2012, Kanya will report at least 2 nights per week of uninterrupted sleep (minimum of 7 hours) for 3 consecutive weeks in which she does not wake up from nightmares.

Interventions

- Rupa Costa, Clinician, will provide supportive counseling once weekly for the next 3 months to assist Kanya in identifying and managing symptoms of trauma and depression that lead to nightmares and sleep disturbance.
- Mita Sinha, Addiction Counselor, will provide once weekly Sleep and Wellness group for the next 3 months to improve sleep habits/patterns.
- Kanya's sister will go with Kanya to the health clinic in the next 2 weeks to get a physical to identify any health problems, including those that may contribute to her problems sleeping.
- Kanya will teach her sister her preferred relaxation strategies, and they will do them together before bed for the next 2 weeks.

Objective

Kanya will maintain abstinence for the next 3 months as evidenced by bi-weekly urine screens collected by her addiction counselor.

Interventions and Action Steps

- Mita Sinha, Addiction Counselor, will provide a once weekly Recovery Practices group to teach Kanya positive coping skills to deal with cravings and manage stressors/symptoms without substance use.
- Kanya will attend a minimum of three local Alcoholics Anonymous/Narcotics Anonymous groups within 2 weeks to explore whether a 12-Step program can be a helpful source of support in learning positive ways to manage stressors and sleep disturbance without marijuana use.

Goal #3

"I'd like to get a job."

Strengths

Recognizes need for steady employment; natural ability making things with her hands.

Barriers/Assessed Needs

Symptoms of trauma, depression, and substance use have contributed to Kanya's lack of stable employment. She is uncertain that she will be able to keep a job because of her frequent irritability and feeling overwhelmed and tired.

Objective

By May 14,2012, Kanya will have a written list of how work will change her life (what expectations she will have to meet and what she can expect to get from a steady job).

By June 14, 2012, Kanya, with staff assistance, will demonstrate her ability to respond to difficult situations that may come up on the job.

By August 14, 2012, Kanya will interview for at least three jobs.

Interventions and Action Steps

- Robin Reza, M.D., to provide medication evaluation and monitoring twice a month for the next 3 months for the purpose of identifying possible medications to address Kanya's reports of sadness.
- Sumon Khan, Employment Coordinator, to provide skill assessment and skill building once a week for the next 6 months to build confidence and skill in interviewing for a job and managing possible difficulties on the job. Employment Coordinator will provide counseling on expectations of employers and what Kanya can expect to get from steady employment. Employment Coordinator will provide instruction in interviewing and managing possible difficulties that may come up in the interview and on the job.
- Kanya's sister has agreed, within the next 6 weeks, to help her collect information from at least six of her friends about where they work, what they do, what their co-workers and work culture are like, and what job opportunities are available there.

Resource Page 5.7: Madhukar's Assessment Summary

Identifying Information, Presenting Concerns, and Living Situation

Madhukar is a 30-year-old male who is experiencing difficulty managing stress, anxiety, and SUD (marijuana and benzodiazepines). He experiences a high level of stress combined with constant worry and insomnia. He is married and has two sons (ages 5 and 7) and describes his marriage as problematic. He states that he can be irritable at times and has made angry outbursts toward his wife. Lately, his worrying about his family has increased as his wife has threatened to take their sons and leave him if he continues using drugs. He feels that his wife has little understanding of his problems and that he worries almost constantly, mostly about providing for his family. When asked to say more about this worry, he talked about his fear of losing his job or not being able to have enough money to support his family; he worries constantly that something might happen to interfere with his ability to work. When asked whether something has happened to cause his worry, he said that there was nothing in particular, just the overwhelming stress of being responsible for two young boys. He reports that he uses drugs to cope with his worry. He reports that he has never been prescribed medication for his anxiety. He obtains his drugs from an acquaintance. Besides marijuana, he has been taking benzodiazepines that he says work better for coping with his anxiety. He is currently experiencing insomnia and, when he does sleep, it is a restless sleep.

Madhukar is employed as a truck driver and says that because of his anxiety, he has trouble concentrating and has had one minor accident while driving on the job. He is afraid of losing his job. He loves his children and doesn't know how he will manage if his wife takes them away from him. For these reasons, he is seeking treatment for his SUD.

Strengths, Interests, and Goals

Madhukar has the support of his employer and is motivated for treatment out of concern about the potential loss of his job and his family. He and his wife have been fighting about his substance use, and he would like to "put things right" with her. He would like to spend more time with his children and be a "better" father than he feels he has been. He says he knows what it is like to grow up without a father, and he wants to be a good father. He wants to stop using drugs and find a way to end his anxiety and stop the worry. He wants to learn how to manage the intense and overwhelming feelings he's experiencing that seem to be the source of the other issues he's experiencing. When asked what interests he may want to pursue outside of work, he said that he used to play football and he would either like to get back on his old team or organize a new one to play in a local league.

Family and Social Support History

Madhukar has three older brothers and said they were close as children. He is close to his next oldest brother and his family and stated that he visits them regularly because his mother lives with them. However, he is not close to his two oldest brothers and he rarely sees them. He heard that his oldest brother had a serious drug problem but got help and stopped using about 2 years ago. He has thought of locating him and is wondering whether this brother could be a source of support as he finds his way in his own recovery.

Madhukar's father had a serious problem with alcohol, left the family when Madhukar was young, and never had much of a relationship with Madhukar. He lost touch with his father and heard that he had died about 10 years ago. Madhukar is closest with his mother and the brother she lives with. Madhukar's only friends are those he uses drugs with. It is through these friends that he has developed contacts for purchasing drugs. He currently has no social support outside of his brother, mother, wife, and children.

Mental Health Concerns, Treatment History, and Medication

Madhukar reports symptoms of anxiety, including insomnia, difficulty concentrating, and frequent irritability with occasional outbursts of anger. He reports no experience of suicidal ideation. He has not sought help in the past, nor has he been prescribed medication for anxiety. He has been using benzodiazepines and marijuana to cope with his anxiety.

Substance Use

Madhukar has smoked marijuana off and on since his adolescence and has begun to use it more regularly in the last year. He says that marijuana puts him in a "different frame of mind" where he can escape from his worries. He continues to smoke marijuana regularly because it is easy to get and is always available. He also takes benzodiazepines because they give him a "calming effect" and help him sleep. However, lately he has had trouble getting the benzodiazepines, and his anxiety level seems much higher than it was when he first discovered its calming effect. He said that without the availability of benzodiazepines, he is smoking marijuana more frequently and that his anxiety is getting worse.

Health Summary

Other than the possible problems caused by his drug use and being tired much of the time as a result of his insomnia, Madhukar does not appear to have any health problems. However, because of all these factors (drug use, sleep problems, and symptoms of anxiety), a complete medical exam is recommended.

Risk/Safety

Madhukar does not report any suicidal or homicidal ideation and does not currently appear to be at risk of harming himself or others. Although he has experienced emotional outbursts, he describes these as stemming from his frustration in his relationship with his wife and reports that he has not become physical. Because Madhukar is a truck driver, there is a risk that he will drive under the influence and harm himself or others in a crash.

Employment and Education

Madhukar completed secondary school and is employed as a truck driver. He also has the support of his employer regarding his desire to enter treatment.

Legal Status and Legal History

Other than a minor automobile accident while on the job as a truck driver, Madhukar has no legal history.

Community Living Skills

Madhukar's living environment has become stressed because of tension in his relationship with his wife. He is dedicated to providing for his family, he has a job, and his employer supports his seeking treatment. He is most concerned about his ability to manage his symptoms of anxiety, worry, and sleep problems without drugs. He is also interested in improving his relationship with his wife and children. He currently has social support from his mother and one brother.

Resource Page 5.8: Sample Narrative Summary—Madhukar

History, Demographics, and Presenting Issue

Madhukar is a 30-year-old man, married with two children (ages 5 and 7). He is employed as a truck driver, and his employer supports his seeking SUD treatment and mental health treatment. His substance use has progressed over the last several years (cannabis abuse; anxiolytic dependence, with physiological withdrawal) and, although there is a history of cannabis abuse, he has been using marijuana and benzodiazepines to ease symptoms of an anxiety disorder (generalized anxiety disorder). Madhukar has experienced much anxiety, mostly in connection with his fear of not being able to provide for his family. He has a strong desire to be a responsible and caring father to his children. And he experiences intense feelings of worry that he will fail as a provider for his family. His father (now deceased) had a serious problem with alcohol and left the family when Madhukar was young. Much of his worry is likely the result of fears that he will also become estranged from his family. In addition to his constant worry, he has anxiety symptoms that include difficulty concentrating, irritability, and sleep disturbances. The anxiety he has experienced in association with these symptoms has led to his increased marijuana use and his use of and gradual dependence on anxiolytic drugs, primarily benzodiazepines. It appears that his symptoms of anxiety came before his substance use, and he will need to be evaluated for an anxiety disorder after he no longer experiences withdrawal from the substances.

Madhukar is motivated for treatment to maintain his job, and his relationship with his family has given him significant reasons for wanting help. He seems to be caught in a cycle of substance use in response to anxiety symptoms and then the substance use results in higher levels of anxiety and increased substance use. He has not had contact with two of his three older brothers, but recently heard that one brother is in recovery from an SUD; Madhukar is interested in contacting that brother to see whether the brother will be a source of support for Madhukar's own recovery.

He is in the contemplation stage of change for stopping his substance use and the preparation stage of change for managing his symptoms of anxiety, keeping his job, and repairing his relationship with his wife.

Summary of Assessed Needs

Madhukar has multiple areas that may need to be addressed in future plans. Those that currently interfere with his primary goals of stopping worrying, keeping the family together, and keeping his job include:

- Symptom management: Madhukar is beginning to understand how his substance use has escalated his symptoms of anxiety. He is worried about his ability to cope with withdrawal symptoms and is willing to be evaluated for detoxification, to learn skills for managing the withdrawal symptoms that result from his substance use, to explore triggers for substance use, to examine lifestyle changes, and to consider alternative activities.

- Worrying: Madhukar experiences intense concerns about his ability to fulfill his role as a father to his two boys. His symptoms include intense worrying, insomnia, difficulty concentrating, and irritability. He is interested in exploring his options for managing these symptoms without marijuana or benzodiazepines.
- Marital relationship: Madhukar's relationship with his wife has become tense, at least in part because of her concerns about his substance use. He feels a lack of trust and understanding from her. This feeling has culminated in intense frustration for Madhukar, and he has experienced angry outbursts. He is interested in repairing his relationship with his wife.

Resource Page 5.9: Madhukar—Two Possible Treatment Plan Excerpts

Goal #1

"I want to stop worrying all the time."

Strengths

Madhukar is employed and his family is still together. He cares deeply about his children and sees the potential for his family to have a healthy future together. He is beginning to see a connection between his anxiety, substance use, and family tension. He is motivated to seek treatment for both his substance use and anxiety disorders. He also recently heard that an older brother, with whom he has not had contact for a significant time, is in recovery from an SUD.

Barriers

Madhukar's anxiety has led to irritability on his part as well as insomnia and difficulty concentrating. His greatest barriers are the cycle of anxiety, substance use, escalating anxiety, and his physical and emotional dependence on marijuana and benzodiazepines. He also experiences intense worry that he may not be a good provider for his family.

Objective #1

Madhukar will maintain abstinence for the next 3 months as evidenced by bi-weekly urine screen results at time of meeting with his addiction counselor.

Interventions

- Robin Reza, M.D., will provide evaluation, monitoring, and treatment for any withdrawal symptoms, three times a week for 6 weeks.
- Mita Sinha, Addiction Counselor, will provide once weekly Dual Recovery Practices group to teach Madhukar positive coping skills to deal with cravings and manage stressors and high-risk situations without substance use.
- Madhukar will attend a minimum of three local NA groups within 2 weeks to explore whether a 12-Step program can be helpful source of support in learning positive ways to manage stressors and anxiety problems without substance use.

Objective #2

Madhukar will report 3 consecutive weeks without irritability, insomnia, and difficulty concentrating as evidenced by self-report in his self-monitoring diary.

Interventions

- Rupa Costa, Clinician, will provide supportive counseling to evaluate symptoms of anxiety and teach Madhukar positive coping skills for anxiety once weekly for the next 12 weeks.

- Madhukar's employer will meet once with Madhukar and his addiction counselor within the next 3 weeks to discuss what is expected of Madhukar to keep his job.
- Within 6 weeks, Madhukar will demonstrate to his clinician four strategies he will use to manage his anxiety and worry.
- Within 3 weeks, Madhukar will initiate at least two alternative activities (e.g., playing football, contacting his brother in recovery) as evidenced by his self-report.

Goal #2

"I want to keep my family together."

Strengths

He loves and cares deeply for his wife and two sons and is highly motivated to do what he needs to do to keep the family together.

Barriers/Assessed Needs

There has been tension in his marital relationship as he has experienced occasional outbursts of anger. His wife has threatened to leave with their two sons because of his continued drug use and the tension in their relationship. Madhukar's feelings of frustration, lack of trust, and feeling not understood by his wife have contributed to his emotional outbursts.

Objectives

- Within 30 days, Madhukar will identify three triggers for emotional outbursts to his counselor.
- Within 60 days Madhukar will sustain a relationship with his wife without emotional outbursts for 3 consecutive weeks, by his wife's report.

Interventions and Action Steps

- Mita Sinha, Addiction Counselor, will provide once weekly anger management group session for 3 months to teach Madhukar positive coping strategies for managing stressful conversations with his wife.
- Within 4 weeks Madhukar will demonstrate to his addiction counselor four coping strategies for managing stressful conversations with his wife.
- Madhukar's wife will participate in the family educational program, once a week for 4 weeks, to learn about the relationship between Madhukar's substance use and his anxiety disorder.
- Aruna Singh, Marital Counselor, will provide once weekly sessions with Madhukar and his wife for the next 8 weeks to identify sources of tension in the relationship and practice strategies for reducing it.

Module 5 - Person-centered Planning, Summary

Narrative Summary

- The term "narrative" is used to emphasize that the summary is developed in the counselor's words and is a narration of the session with the client.
- The narrative summary is a bridge between the assessment and the plan. The assessment itself is not sufficient for service planning.
- The narrative summary is the counselor's impression of what is going on with the client, an understanding about who this person is. This part of the process may be the most difficult.
- Direct statements from the person being helped can also be an important aspect of a complete narrative summary.
- If insurance of other third parties are paying for treatment, then the narrative summary may be required and used to justify the level of care being recommended.
- It is common to open the summary with a brief demographics statement that includes
  - Identity (age, culture, spirituality/religious affiliation, sexual orientation, etc.);
  - Presenting issues (Why is the person here? Why now?);
  - Psychological or recovery environment (consider housing, employment, support system, acute/ chronic stressors, etc.); and
  - Strengths, preferences, and priorities (personal talents/interests/coping skills as well as natural supports and community connections).
- The narrative summary answers questions about:
  - Why treatment is needed at this time;
  - What barriers need to be addressed to support the person in moving toward his or her goals; and
  - Appreciation of the role of the person's culture and ethnicity in his or her experiences and recovery.
- The narrative summary is shared with the person and recorded in the person's treatment chart. It should reflect mutual understanding between counselor and client of the impact of these areas.
- There are other names for this document that we are calling a narrative summary. It may also be called an "interpretive summary".
- The narrative summary also describes:
  - Diagnosis (with rationale, as appropriate, and a focus on how symptoms are interfering with functioning and life goals—includes consideration of significant health issues); and

- Your hypotheses—The central themes, insights, understandings, and so on that you believe set the stage for effective change efforts.

- Some narrative summaries may also include - Stages of change for specific behaviors and decisions—for example, many people have co-occurring disorders, and they may be in different stages of readiness for addressing substance use and mental health issues.

- It may help you in developing the narrative summary if you have included a discussion with a structured form (SNAP) about person's
  - STRENGTHS What personal qualities do you have which we can build upon in treatment?
  - NEEDS What would help you achieve your goals?
  - What ABILITIES do you have now?
  - And what PREFERENCES do you have for your treatment?

- For strengths examples may include
  - Open minded, Friendly, Creative, Good Listener, Fast Learner, Good Grooming, Organized etc.
  - NEEDS What would help you achieve your goals? Consider having people check their most important needs. (Prioritize your top three) develop items that relate to the ASI and other issues with a space for writing other issues
  - Abilities What skills do you possess? Again, check off boxes are helpful with blank spaces for writing other issues
  - Preferences How do you want your treatment? Items to check off may include- I prefer my family or friends to be involved in my treatment, I would like to have a family meeting I learn new information better: Face to face treatment, virtual treatment,
  - Hands on instruction and practice, etc.

- The narrative summary is where the counselor takes the data and weaves them together in a way that creates a comprehensive understanding of what's going on with the person. It is more than a summary of the need areas. It is the interrelationships in the assessment information. For example, how are the person's substance use, physical health issues, and mental health issues related? What seems to be going on with the person?

- This is a significant opportunity for the counselor and client to develop a shared understanding about how these areas combine to affect the person's life and what might help. This part of the narrative summary provides the rationale for the services and interventions the person could be offered.

- The bottom line of all of this: Individualized planning, individualized care.
- Deficit and problem-focused language makes decisions for people;
  - Leads to plans that are about controlling behavior without understanding what causes the behavior, what it means to the person, and what the person can do differently to address the reasons for the behavior;
  - Does things for clients that they can do for themselves;
  - Views treatment noncompliance as a person's failure rather than as a problem with treatment planning.
- With a deficit approach, a person who reads his or her plan often has the feeling that it is not about him or her, that the plans do not seem to describe the client accurately. No matter how hard working and compassionate the counselors are, the unfortunate result of this approach is to encourage clients not to take initiative.
- On the other hand, in contrast to problem focused-language, recovery-focused language involves:
  - Working together with client to identify strengths, assets, barriers, and the ways to overcome barriers to achieve goals; and
  - Recognizing and respecting the autonomy and integrity of the person while providing expertise that may be helpful.
- Often, counselors refer to the barriers people experience in judgmental terms or jargon that reflects a deficit focus.
- Here are some examples of language that is sometimes used to describe barriers people experience in moving toward their goals:
  - "Client has low self-esteem."
  - "Client is in denial."
  - "Client is alcohol dependent."
  - "Client is promiscuous."
  - "Client is resistant to treatment."
  - "Client is on probation because he is an addict."
- It is important to be able to identify barriers in the narrative summary in a way that describes the person's behavior without judgment or jargon to maintain a focus on recovery. Let's look at the statement, "The client is promiscuous."

Person-Centered Planning

- Person-centered planning is:
  - A collaborative planning process that supports the preferences and recovery of the person receiving services. It fosters a recovery orientation by which any service plan of care, individual action or treatment plan, is developed by the client and counselor.
  - It is a process directed by the person receiving services in partnership with treatment providers and natural supports; and
  - Is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the person served.
- Most of us can relate to the natural tendency toward learning and growing. We also encounter barriers to thriving such as feeling overwhelmed by chaos in our inner lives and our situations that interfere with our ability to learn what we need to do to live in a way that feels in line with our values and hopes.
- Person-centered planning supports clients in gaining the knowledge and skills they need to create lives that feel worthwhile and meaningful: A fulfilling life with or without the challenges of symptoms of SUDs, medical disorders, and mental disorders.
- It also allows the client to assume responsibility for the outcomes of his/her treatment.
- Person-centered planning:
  - Balances person-centered approaches with eligibility criteria to partner with people and support recovery.
  - A person's eligibility for services is generally based on assessment of clinical need and the demonstration of how the planned services support movement toward improved quality of life and functioning;
  - Honors the experience, goals, and values of the person. Treatment providers fully understand that the client is the expert regarding his/her preferences, and that he/she should take a more active role in his/her treatment planning. The individual client's ability to direct the care planning process is never undermined/compromised; and
  - Satisfies documentation requirements.
- In person-centered planning, it is important to consider the following:
  - Inclusion of the person's natural supporters in the care planning process
  - Articulation of clearly defined short and long-term personal goals with measurable objectives;
  - Assignment of responsibility for different tasks and action steps to different members of the care team including the person in recovery; and,

- Use of tools such as psychiatric advanced directives, shared decision-making aids, and supported employment, housing, socialization and education coaches.

- The client should experience his or her relationships with treatment providers as empathic, trusting, hopeful, empowering, encouraging, understanding, respectful, and collaborative.

- Key practices in person-centered planning include the following:

  - Shared decision-making: The client should be a partner in the planning meetings, including when and how the meetings occur (e.g., what time, who should be invited) and shaping the contents of the plan. We want people to come prepared, knowing what they want from their treatment. We want them to shape the contents of the plan, so it supports them in moving toward their goals.

  - Considers both the Client's action steps and what his/her provider is going to do towards goal attainment.

  - People also appreciate having some reasonable control over the logistics of when and where treatment plans will be developed so they can invite family members and/or other people who are important to their plan to take an active part in the process of creating their roles in the plan.

- Remember, the client should always be offered a copy of the plan; it is the client's plana and there are tasks on it for him or her to do. It helps people stay focused on moving toward their goals: "Why am I here?" or "What am I trying to achieve?"

- Finally, when we know we are putting a copy of the plan in the person's hands, it changes the language we use.

- A good plan is a road map. It provides hope by breaking a seemingly overwhelming journey into manageable steps for both the counselor and the person being served. For example:

  - Assessment;

  - Development and implementation of the plan (goals, objectives, interventions); and

  - Discharge from services.

  - Envisioning what is needed for the person to be ready to be discharged is a part of the plan from the beginning.

Supporting Recovery: Dimensions

- Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

- The four major dimensions that support a life in recovery are:

- **Health:** overcoming or managing one's condition(s) as well as living in a physically and emotionally healthy way;
- **Home:** a stable and safe place to live;
- **Purpose:** meaningful daily activities, such as a job, school, volunteering, taking care of family, and creativity, as well as the independence, income, and resources to participate in society; and
- **Community:** relationships and social networks that provide support, friendship, love, and hope.[28]

■ For a person to truly develop and implement a person-centered plan, there has to be a culture in place that supports recovery and wellness. If counselors don't believe that the people receiving services can recover, it is impossible to implement person-centered plan. The belief in recovery and wellness has to happen first.

Developing a person-centered treatment plan

■ This is a model for building person-centered treatment in a thoughtful way:

- Starting from the bottom of a pyramid, the process begins with the person requesting services or being externally motivated (for example, court referred) to receive services;
- Assessment—data gathering—follows, including gathering information from referral sources, previous discharge summaries, and, of course, the person;
- Understanding holistically who the person is: not just his or her diagnosis, not just the facts, but your impression of who this person is whom you are meeting with;
- Prioritizing, or deciding (with the person,) where to start;
- The goal or goals you're going to work on;
- Identifying the person's strengths and the potential barriers to reaching the goal; (these are collected during the assessment; the barriers are the SUD challenges that are getting in the way of the person's being able to achieve goals);
- The objectives of the plan are then written to best use strengths and to overcome the barriers; and
- Services and supports are offered professionally and found in the natural environment to help people achieve their objectives.

■ Finally, the desired outcome is that people develop the skills and knowledge to support their own recovery and wellness.

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[28]Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's working definition of recovery updated. Blog entry on March 23, 2012. Retrieved on August 26, 2012, from http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated

Assessment

- A person-centered plan is only as good as the assessment, and the assessment is only as good as the relationship that it is built upon.
- The counselor needs to combine the information collected by an assessment instrument like the ASI (e.g., substance use, legal history, family history, employment history, and so on) with the information about what is going well in the person's life. The counselor also needs to know enough about the person to have an idea about what barriers the person may encounter. When the counselor has identified specific behaviors or decisions that may be getting in the way of the person's goals, he or she can then assess how ready the client is to begin making changes.
- The assessment that sets the context for a person-centered approach to planning involves the kinds of conversations that build relationships, discover strengths, and encourage hope while also gathering the information needed to support an effective plan. Here are some areas of a person's life that can help the counselor build connections and understand who the client is:
    - Personal strengths. "What are you most proud of in your life? What is one thing you would not change about yourself?"
    - Interests and activities. "If you could plan the 'perfect day,' what would it look like?"
    - Living environment. "What are the most important things to you when deciding where to live?"
    - Employment. "What would you like to do? What type of employment interests you?"
    - Education and skills. "What are your educational goals? What knowledge and skills do you have?"
    - Financial resources. "What are your financial resources?" (e.g., income, savings, access to health care).
- Here are some other areas of a person's life that can help us build connections and understand who the person is:
    - Lifestyle and health. "Do you have any concerns about your overall health?"
    - Personal choice and control. "How much control do you have over your well-being?"
    - Transportation. "How do you currently get from place to place?"
    - Faith and spirituality. "What type of spiritual or faith activities do you/would you like to participate in?"
    - Relationships. "Who is the person in your life who believes in you?"
- An assessment process that incorporates questions about these areas of a person's life sets the stage for moving beyond just collecting information to understanding

both the person's strengths and the barriers to the person's moving toward his or her goals.

- In examining priorities, we need to determine where to start.
  - What are the client's goals; what is important to him or her?
  - To stay out of jail, reconnect with family, take care of health issues?
    - To stay out of jail?
    - Reconnect with family?
    - Take care of health issues?
- Prioritization is guided by:
  - Personal and family values
  - Cultural nuances
  - Personal concerns and perspectives
  - Personal strengths and expertise
- Counselors may have priorities like:
  - Basic health and safety;
  - Reduction of symptoms;
  - Fulfilling legal obligations; and
  - Community safety.
- Sometimes there are things that a person has to do, but they are not necessarily the person's goal. Instead, these things can be incorporated into the person's objectives or interventions. This integration makes it possible to really join with people on their goals (e.g., "get reconnected with my family") while simultaneously working with them to address the barriers (e.g., what they have to do) to reach their goals.
- Finding common ground between counselor and client respects personal choices and control:
  - It implies a counselor's ability to provide choices over a wide range of options
  - It does NOT view either the counselors or person receiving services as having failed if a choice does not work out
- Goals are linked to the person's hopes, dreams, and meaningful roles: what they want from this treatment experience.
- Goals should reflect, functionally, what the person will be doing differently as an

outcome of treatment.

- One way to set a goal is to ask, "What do you want to be different in your life as a result of coming here?" In short, the person's life changes as a result of services.
- As much as possible, the counselor should use the person's own words for the goal. Goals should be expressed in language that is as positive as possible. This is another opportunity to give people hope. Goals can be a big piece of engagement. Think about how people feel about working with you on their goals. It's a different conversation from "This is what you should be doing."
- You see a lot more forward movement with a meaningful goal expressed in hope-filled language:
  - "What would you really like to be doing in one year?"
  - "If you were less depressed, what would you be doing right now?"
  - "When you were less depressed, how was your life different? How can we get back to that?"
- The goal should be consistent with the person's desire for self-determination. This may be influenced by culture and tradition.
- Here's an example of a goal as defined by a person living with heroin dependence. In the midst of a fight, Rajib became verbally threatening and shoved his wife in front of their children. His wife kicked him out and won't let him see the kids.
- Rajib's primary goal is to see his children: "I want to reunite with my family." His plan needs to include concrete, measurable, short-term, and objective proof that he is moving closer to his goal.
- For example, his treatment plan says,
  - "Objective #1: "Within 1 month, Rajib will demonstrate ability to use three anger management skills."
  - "Objective 2: Within 60 days, Rajib will have a minimum of one successful visit with his kids as reported by his wife."
- You are going to actually try to help Rajib see his kids in 60 days.
- Rajib's assessment indicated that cravings played a role in his threatening his wife in front of his children and other impulsive behavior. He didn't have adequate coping strategies so instead he got physical with her. Rajib also has lots of strengths to work with: He's a very hard worker and a very committed father.
- The interventions might include:
  - Mutual support groups; and
  - Anger management groups.
- The plan opens the door to counseling to address his relationship with his wife. This

approach helps people see how the services we have to offer serve their goals.

- Counselor often use a problem statement, like "Heroin dependence, "as a goal.
- Another goal frequently seen in treatment plan is, "Will refrain from all substance use now and in the future." Again, it appears that, if the person attends the outpatient program, if he or she sees the counselor and attends groups, he or she will no longer use substances. No client ever comes into treatment saying, "That's what I want for my life, I want to refrain from all substance use now and in the future; that's why I'm here."
- Those are our goals for people, and that's what we are trying to move away from.
- Along with incorporating a client's strengths, treatment plans also need to address potential barriers to goal achievement.
- Simply saying "family problems" or "job problems" isn't specific enough. Being more descriptive helps us understand what may help the person overcome the barriers and documents the symptoms the person is experiencing. Your comprehensive assessment and narrative summary lay the groundwork for understanding how symptoms and other barriers interfere with the person's functioning. This is also how you demonstrate just how the person meets the eligibility criteria for services.
- Now let us look at how we use those data in our understanding of the impact of these barriers on clients' ability to move toward their goals.
- If someone drops out of treatment before completion, that is an important piece of information. If the narrative summary just says that the person has a history of leaving treatment early for the past several years, that is not going to be good enough. We need to create a hypothesis about why someone doesn't stay in treatment. Incorporating the person's perspective makes a big difference in the plan:

  1. Leave no blanks;
  2. Mark an "X" if the question is not answered;
  3. Mark an "N" or "NN" if the question is not applicable;
  4. Follow the half-time rule by rounding up; and
  5. Note that a bullet (•) indicates hints and clarification.

- The first instruction is leave no blanks. This means the interviewer should:

  - Does the person prefer alternative coping strategies (e.g., exercise, meditation, acupuncture, structuring time, spending time with family)? If so, has the individual created a plan for when treatment services should be used?
  - Is the person ambivalent about staying in treatment? If so, what does he or she already understand about the risks and benefits of treatment? What were the person's experiences with treatment in the past? What does he or she think might work?
  - Does the person not recognize that he or she is experiencing symptoms or barriers

to goals? If so, you have to have a much smaller, more modest objective that incorporates exploring the client's own understanding of his or her difficulties and ways of reducing, coping with, or eliminating symptoms and barriers while eliciting ways to live a more productive, satisfying life. With permission, you can offer different opportunities for psychoeducation— (e.g., a conversation with a peer specialist about his or her decision to enter treatment, non-stigmatizing descriptions of how other people have coped with these difficulties).

- Does entering treatment interfere with important experiences in the person's life? If so, a plan that ignores this element is doomed to fail.
- Does the person's family object to the individual's coming in for treatment? If so, the family members may need to have an opportunity to talk about their concerns and learn more about treatment and options.
- Does the person's culture not recognize treatment as an appropriate method for addressing the person's experience? If so, you may need to incorporate the relevant members of the person's culture into the planning process.

Objectives: SMART

- Once we understand the client's strengths, goals, and potential barriers to achieving those goals, the next step is to break goals down into objectives. What does the person need to do differently so that he or she can reach his or her goals? What behavior changes does he or she need to make? What specific steps will help the client reach his or her goals?
- Objectives should be written so that they are:
  - **S**pecific. The specific behavioral change should be written in language the person understands. If this is the person's plan, if the person is going to do this task, change this behavior, then it needs to be written in a way that the person will clearly understand it. And it should clearly support progress toward the person's goal.
  - **M**easurable. Can you say it definitely happened or didn't happen? It can be measured "by self-report," or maybe someone else agrees to tell you something about what the person is doing. It can be measured on a scale of 1 to 5 if the person is working on decreasing the intensity of a symptom (e.g., feelings of sadness). Behavioral changes can be measured using counts (e.g., number of clean urine screens, days of medical problems).
  - **A**chievable. We want people to be able to have success and build on success, so we focus on "improved functioning" rather than the "end" or "cure" of the problem (e.g., "number of employment interviews" rather than "become employed full time").
  - **R**ealistic. Whether an objective is realistic is going to depend on the person's current level of functioning, readiness for change, environment, and supports.
  - **T**ime-bound. Not all objectives should be allotted the same amount of time (e.g., everything needs to be achieved in 90 days because that is when the plan needs

to be reviewed). A person may be able to learn something in 2 weeks and need 6 months to apply it.

Specific

- Here are two ways to frame objectives to make it easier to identify what specific changes are expected:
  - "Within X days, the individual/family will…"
  - "As the result of services and supports, Mr. X will..., as evidenced by…."g or technical education:

Measurable

- **Here is an example of a desired change: The client will decrease arguments with this wife.**
- And here are two examples of measurable objectives:
  - Within 30 days, Zahid will demonstrate to the counselor three new communication skills.
  - Zahid will participate in a minimum of one conflict resolution group each week for the next 60 days.
- Talking about barriers to achievement can help determine this aspect of the objective. What would you ask him to determine how realistic this is?
- When objectives are not met, you will want to go back and think about what needs be done differently. A more modest goal may be more appropriate. Here is an example of a desired change: Client will decrease frequency and intensity of substance use.
- And here are two examples of measurable objectives reflecting different stages of readiness to make a change:
  - Within 30 days, Nipu will identify to the counselor the time of the day that is easiest to give up cannabis and practice being cannabis free at that time. This means if he smokes cannabis 4 times a day 7 AM, 9 AM, 5 M and 10 PM, and he determines that the 9 AM typical cannabis smoking time is the easiest one to give up, he will practice this action at least 6 times in the next 30 days.
  - Nipu will be substance-free for 6 months as evidenced by negative urine drug tests administered randomly (action).
- Here's an example of how the nature of a barrier could change the objective for same goal: Client will adhere to methadone dosing schedule.
- What is the barrier?
- Family stigma?

- Within 30 days, Refat will share with his family the information on the benefits of taking methadone for himself and his family

- Simply participating in services is not an objective. For example, "Mithee will consistently attend all appointments with her counselor over the next 3 months."
- There are times when a counselor does include the intervention in the objective. For example, when the task of treatment is to engage him or her into services, then you might write an objective that sounds like this: "Mithee will demonstrate increased engagement in care as evidenced by her attendance at 75 percent of her appointments with her counselor over the next 3 months."
- A maximum of two or three objectives per goal is recommended to create focus and reduce the chances of the client feeling overwhelmed. Check-in with the client to see how many objectives they feel comfortable with developing. Have a conversation with the client to find the right balance.
- A process-oriented objective can be used if it is the most ambitious step the person takes based on functioning or severity of illness: For example,
  - Within 2 weeks, Wei will contact two potential employers.
  - Within one month, Wei will complete three job applications.
- To be an effective road map, the plan can have some smaller steps. These are markers along the way to the big goal, which might take months or years. The objectives should break the tasks or changes down into short-term, outcome-oriented goals so the person can have some success. For example:
  - Goal: Wei wants to get a job.
  - Outcome-oriented objective: Within 1 month, Wei will complete four job interviews.
- Some guidelines for writing achievable objective include:
  - Start where the person is; this means being mindful of the person's stage of change and level of motivation;
  - Be as ambitious as possible while ensuring that objectives are achievable; and
  - Increase expectations over time to support the person's progress toward his or her goals.
- Let's talk about increasing expectations. For example, if the desired change is that the client will stop using all substances, the counselor could do the following:
  - An initial objective could be: "Borna will complete an intake interview for SUD treatment within 2 weeks."
  - Once Borna has entered the program, the objective could change to: "Borna will create a plan that supports her in obtaining an NA sponsor within 30 days."

- As Borna becomes more involved in the program and in mutual-help groups, the objective could be that: "Borna will remain drug free as evidenced by negative urine drug tests over the next 90 days".

- Your plan needs to change dynamically over time. The place you are most able to demonstrate change is in the shifting of the objectives over time. Your long-term goals may remain in the plan for a long time, but the objectives need to change.

- Here is another example of increasing expectations over time by shifting objectives. In this case, Borna's long-term goal is to improve her parenting skills:

  - Borna will identify, with her counselor, three preferred relaxation skills within 2 weeks.

  - Borna will demonstrate her ability to use three conflict resolution skills within 1 month in her conflict resolution group.

  - Borna will have three non-confrontational conversations with her son within 2 months as evidenced by her sister's report.

- Assessment and feedback provision help improve treatment outcomes. So, it is necessary to:

  - Review treatment plans on a regular basis.

  - Assess if the goals are adequate and determine if there is a need to reformulate those goals. This is because unforeseen situations can occur in course of treatment, that may require reformulation of the existing goals or formulation of new ones.

  - Assess if treatment interventions (activities) have been effective and replace them with others if these interventions were ineffective.

- How do we assess the treatment goals? What should we consider? Are there simple tools that can help in this task?

  - It is advisable to look into the level or degree of goal attainment that the person served considers acceptable or successful. For this, "scaling questions" or "extreme scales" can be used.

  - It is a technique that prompts the persons served to think in terms of a Visual Analogue Scale (VAS), which inquire into the persons 'own perception of their behavioral changes.

- The Visual Analogue Scale is a results evaluation method that monitors/measures achievement – from the client's point of view – of the goals defined for the treatment.

- In general, a scale of "1 to 10" is used, with 1 representing the behavior before the person had sought therapeutic help or before entering treatment, and 10 the changes he / she hopes to achieve (the indicators of success).

- In monitoring the attainment of the goal, the person can compare his/her score in successive VAS, which can facilitate the person's reflection/recognition of the actions that have allowed him/her to advance in his/her route (which encourages self-efficacy) or think/explain the scores' setback.

- Remember: Treatment plans need to be living, breathing documents. They must change over time to remain motivating and relevant. For example, if Mitthee met the objective of attending 75 percent of her appointments with her counselor over 3 months, you need to write a new objective with increased expectations.

The Mapping Technique

- One of the biggest "disconnects" between SUD Counselors and their clients center around treatment planning. Counselors often believe clients are not capable or motivated enough to contribute in the development of their treatment plan. Clients, on the other hand, often have low expectations of being involved by counselors in their treatment planning process.
- Mapping techniques explained in this section help to bridge this gap. These techniques analyze problems and situations through graphical representations (or mapping) of information, ideas or suggestions from the clients and thus encourages clients to talk about their goals, the changes they want to see in their lives, their ideas about the best way to make those changes, and their considerations about how to measure their progress in the path of recovery.
- This type of collaborative, future-focused treatment plan has the best chance for success because, with the help of mapping strategies, clients are assisted in articulating and claiming the ownership of the treatment plans and journey.
- The mapping techniques are effective, affordable and evidence-based technical tools and resources.
- Controlled clinical studies have demonstrated the effectiveness of the mapping techniques in the treatment of adults and adolescents.
- Mapping is a cognitive tool that helps organize information and ideas spatially. It may have key ideas written in boxes that were connected to other boxes with lines ("links") representing different types of relationships. For example, Genograms use boxes and lines to help clients better understand their family history over several generations.[29]
- Maps are co-created, and the content of a map – the thoughts, ideas, and issues – are those raised and identified by the client. The map provides a focal point for this work as the counselor skillfully elicits from the client what should be written down, what should be noted in passing, and what should be addressed next.
- We will review three types of Maps:

1. Information or Knowledge Maps
2. Free Maps
3. Predesigned Maps or Guide Maps

1. Information or Knowledge Maps

- Information or knowledge maps are used to communicate basic information in a readily understandable way. These maps organize facts in a specific content area and present them in an easy-to-remember format. They may be prepared ahead of time to serve as handouts. They can represent theoretical models, knowledge structures, and technical procedures.
- Studies indicate that information maps should contain between 6 and 20 boxes (nodes), depending on the client's cognitive style and prior knowledge. Early mapping studies with clients attending psychoeducational groups on HIV-risk reduction found that information maps were useful in helping clients learn and retain information about HIV transmission and high-risk practices.

2. Free Maps

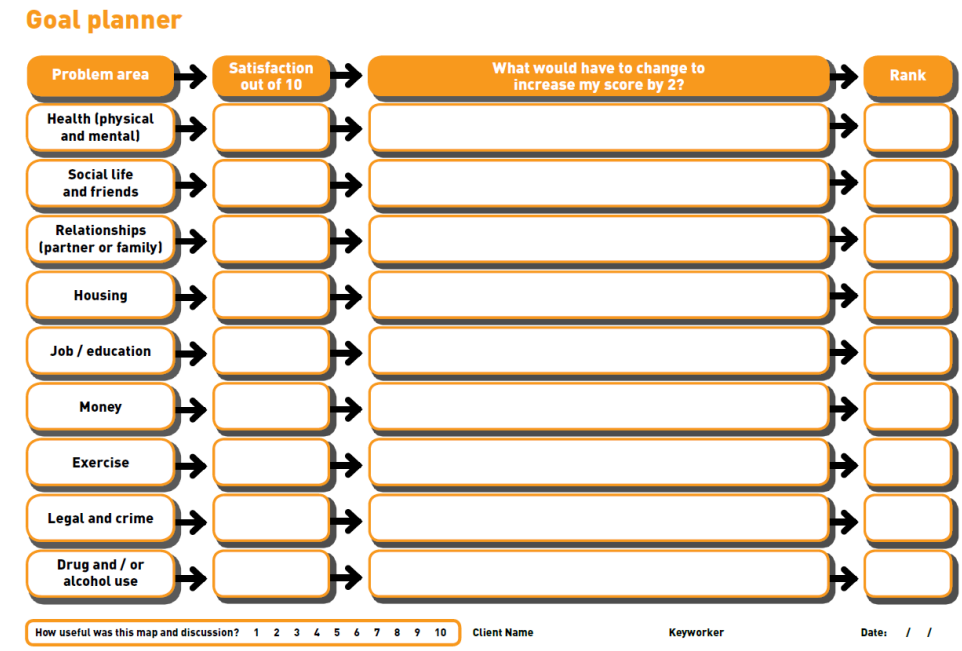
- Free maps are built on a blank sheet and seek to represent the idea that are being discussed. Using an erasable board, flip chart, or paper and pencil, client(s) and counselor can work together to create a free map of the problem or issue under discussion. The counselor should take the lead in briefly explaining free mapping to the client(s) and providing a starting point for creating the map. However, when at all possible, both counselor and client(s) should have pencils or markers so that co-creation of the map is facilitated. The counselor teaches the client to build the map, or they can build it together.

3. Predesigned or Guide Maps

- Predesigned maps or guide maps consist of a template with blank spaces to be completed by the person in treatment.\
    - They are used as a graphic tool to facilitate exploration on various intervention topics.
    - They can also be turned in as homework and reviewed in the next counseling session.
- The mapping technique can help clients identify salient goals to work on as part of treatment and to narrow those goals down to clear, specific, and practical plans.
    - A subsequent map is used to invite a conversation about specific steps to take first, followed by a map focusing on the personal strengths the client brings to deal with identified problems.
    - Next, a "planning rocket" guide map is used to summarize the session and provide the client with a reminder of tasks for the coming weeks.

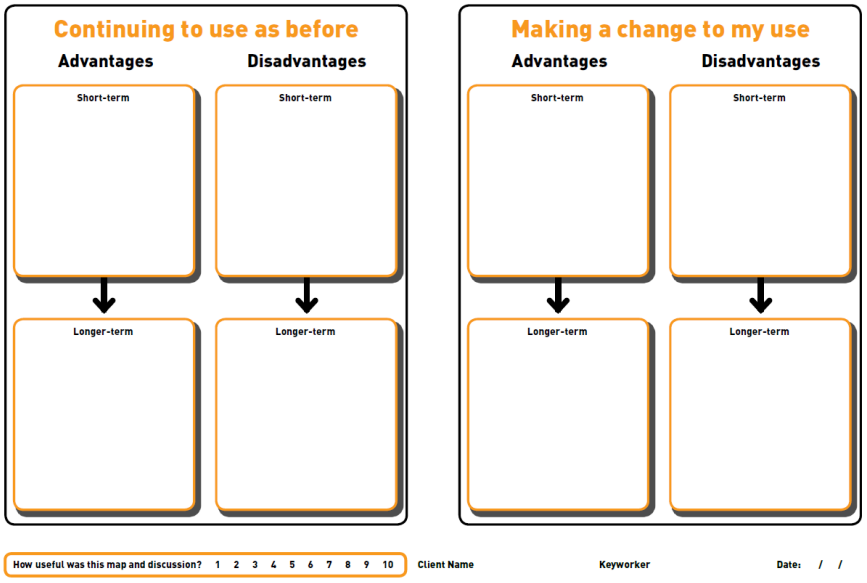
[29]This document was prepared by the SENDA Treatment and Rehabilitation Area (2018), based on an adaptation of .(the Mapping Guidelines of the Institute of Behavioral Research at Texas Christian University (TCU

- The maps developed by the client and the therapist can be:
  - Handed out as a reminder of the session or as homework assignments between sessions.
  - Reintroduced by therapists in the sessions to assess changes and progress
  - Useful for continuity of care. The worksheets or notes can be placed in the client's file, so that discussions of treatment issues (around goals, for example) can be picked up where they were left off at the end of the previous session.
- The use of the mapping technique can create a sense of collaboration, by withdrawing attention from the client and placing it on a graphical representation of the topic that is being addressed. This can reduce the anxiety of those who feel uncomfortable with eye contact. The technique can thus help the client and the therapist generate more ideas in comparison with sessions that uses conversations only. Moreover, the technique can be used for clarifying information between counselor and client.
  - It can be used effectively with whatever therapeutic orientation or style a therapist follows.
- This manual entitled "Routes to Recovery" is published by Public Health England. It contains tools and techniques to improve the assessment and carry out a recovery plan for people with substance use disorders. The manual details the common parts of effective treatment. It uses the concept of node-link mapping to support the delivery of these techniques and is organized into sessions.
- The manual covers the following topics:
  - Techniques and tools to enhance assessment and build a plan for recovery
  - Setting, achieving and rewarding goals
  - Building social support for change
  - Providing information to reduce harm
  - Skills development
  - Exiting treatment and aftercare (also known as continuing care)
- One of the key tools used in this manual for enhancing assessment and building a recovery plan is "node-link mapping."



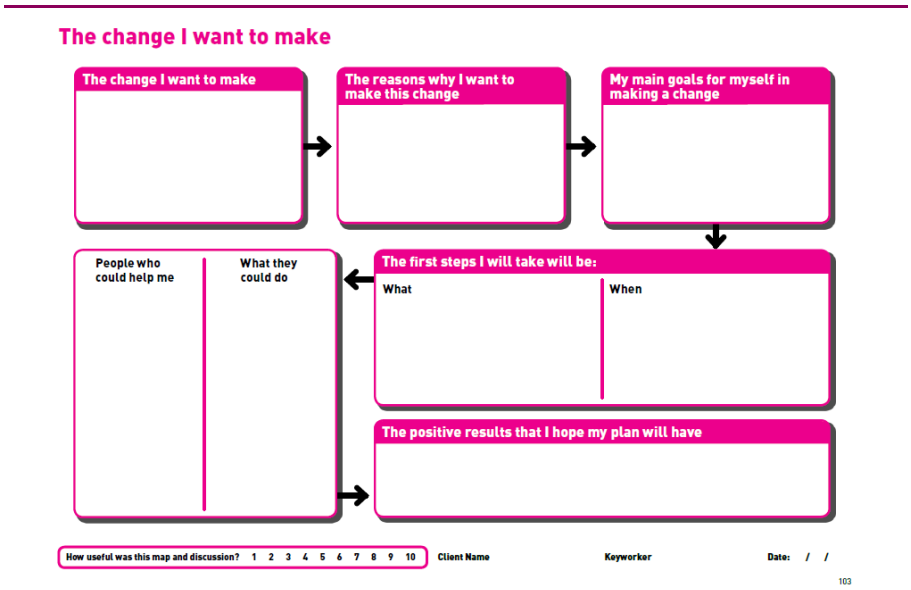
Day E (2013) Routes to Recovery via the Community, Public Health England, London.

- Therapeutic work is most effective when there is structure and goal direction. By using the 'Goal planner" technique a therapist can work with the client to set effective, SMART goals for the aspects of their life that are most important to them.[30]
- The "Goal planner" technique encourages clients to think about making changes in all areas of their life, not just their substance use.
  - Once an initial area of work has been settled upon, simple reinforcers can be used to reward goal achievement.
  - Positive changes in one area encourages clients to make changes in other areas of their lives.
  - The technique also helps clients learn from their failures to achieve goals – the client explores if the original goal was a SMART one and/or if it could be broken down into smaller steps?
- When using this technique, therapist would:
  - Ask the client to complete the 'Goal planner' by considering each of the areas listed in the first column and rating them between 1 and 10. A score of 1 means that things in this area could not get any worse, and 10 means things could not be any better.
  - Go through each of the areas and discuss what the score means to the client. For example, if the client rated 'Money' as 3, what would have to change to make it a 5?



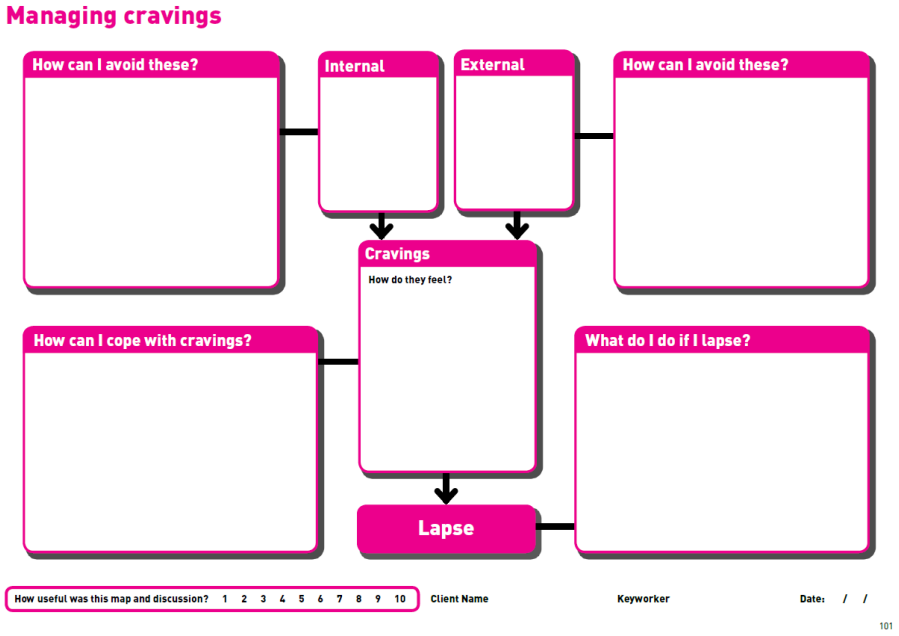
Day E (2013) Routes to Recovery via the Community, Public Health England, London.

- Clients entering drug treatment usually have some degree of ambivalence about changing and tackling their problems.
- The "Decisional Balance Sheet" is a simple but effective mapping technique that helps clients explore and resolve this ambivalence by drawing their own reasons for change.
- Below is another mapping exercise that helps a client to talk about the changes he/she would like to make.


The change I want to make
The change I want to make
The reasons why I want to make this change
My main goals for myself in making a change
People who could help me
What they could do
The first steps I will take will be:
What
When
The positive results that I hope my plan will have
How useful was this map and discussion? 1 2 3 4 5 6 7 8 9 10
Client Name
Keyworker
Date: / /
103

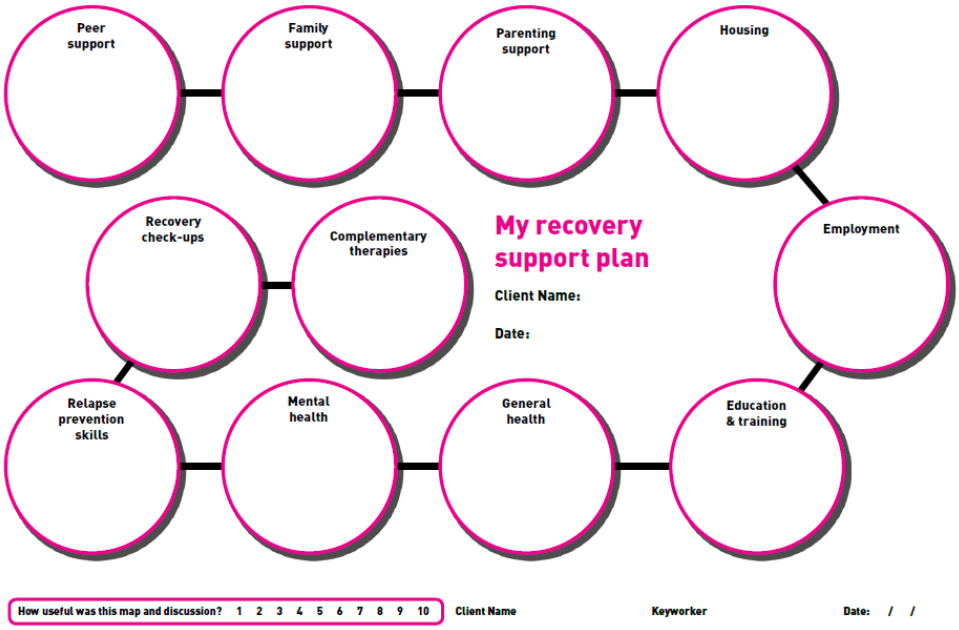
Day E (2013) Routes to Recovery via the Community, Public Health England, London.

- Below is one of the mapping exercises that can be used during a session on what happens with a return to use. It helps clients understand their triggers and craving and allows a discussion on how they can manage their craving.



Day E (2013) Routes to Recovery via the Community, Public Health England, London.

- "My Recovery Support Plan "allows a structured discussion on the key areas that should be considered for an exit recovery plan at the end of a treatment episode.



Day E (2013) Routes to Recovery via the Community, Public Health England, London.

Interventions (Services)

- A treatment plan needs to indicate what interventions will be provided in support of the client's goals. Interventions are planned services or strategies or methodologies. Usually these are the services counselors provide, but they may include any kind of natural supports that the person might have in his or her life. This is also where efforts to build natural supports are documented.
- Interventions, or services, are actions by staff members, the client, and the client's family, peers, and natural supports that: peers, and natural supports that:
  - Respect the client's choice and preferences;
  - Are specific to the stage of change and recovery;
  - Describe the reason for the intervention; and
  - Are specific to the client's goals and objectives.
- Interventions clarify who does what and include tasks for:
  - The client;
  - A family member; and
  - Other natural supports.
- Descriptions of interventions should include five critical elements:

1. Who's doing it;
2. What is being done;
3. On what schedule (frequency, intensity, and duration);
4. Where it is being done; and
5. The purpose, or desired outcome, of the intervention.

- Name the person delivering the service, his or her role, and what specifically the person is doing. If you aren't sure how frequently a service will be needed, make a guess instead of defaulting to "as needed." If you take your best guess about how frequently something will happen and then it's needed less often, you can use the fact that the service was needed less frequently than anticipated as rationale for decreasing the frequency when you update the plan.

Person-Centered Planning: Continuing Care

- "Treatment plans in recovery-oriented care mainly consider psychosocial and medical care but professionals from different fields participate, depending on the care needed. These professionals must function as a multidisciplinary team and also include supportive friends and family."

- "The plan should include personal strategies to prevent drug or polysubstance use (with a high risk of overdose); maintain housing; secure or hold employment; establish or sustain positive social networks; and re-integrate into the community. Plans should also include rapid access back to treatment if the patient has a return to use."
- Finally, the outcome of successful person-centered treatment planning is that people develop the skills and knowledge they need to support their own recovery and wellness.
- There are times when we may not have all of the resources, we need to help make all issues better, but if we have good communication and shared-decision making with the person being served, the changes of successful outcomes are increased.

MODULE 6

PERSON-CENTERED PLANNING

Content and Timeline 383
Training goals and learning objectives 384
PowerPoint slides 385
Resource page 412
Summary 418

Content and Timeline	
Activity	***Time***
Introduction to Module 6	10 minutes
Interactive Presentation: Essential Forms for Documentation	15 minutes
Break	*15 minutes*
Interactive Presentation: Waiver/Informed Consent	20 minutes
Interactive Presentation: Flow of Forms Screening -	20 minutes
Interactive Presentation: Purposes of record keeping	30 minutes
Day 4 Wrap-up	10 minutes
End of Day 4	
Review of Day 4	10 minutes
Small Group Exercise- Documenting eligibility	50 minutes
Interactive Presentation: Progress notes SOAP note format	30 minutes
Break	*15 Minutes*

Content and Timeline	
Activity	***Time***
Small Group Exercise- Progress notes	30 minutes
Individual Exercise- Progress notes	15 minutes
Reflective Exercise- Documentation	15 minutes

Module 6 Goals and Objectives

Training goals

- To give participants an overview of the importance of documentation;
- To give participants information on the elements of structured documentation;
- To give participants an opportunity to practice documentation; and,
- To give participants an opportunity to reflect on current practices of documentation in their work environments.

Learning objectives

Participants who complete Module 6 will be able to:

- Describe the importance of keeping accurate and complete client records;
- List five guidelines for effective documentation;
- Explain the importance of documentation in the process of screening for treatment eligibility;
- Explain the SOAP format of progress notes; and,
- Demonstrate writing SOAP notes based on a case study.

UNIVERSAL CURRICULUM
Treatment of Substance Use Disorders
The Universal Treatment Curriculum for Substance Use Disorders (UTC)
UTC 5
Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals
MODULE 6—RECORDKEEPING (DOCUMENTATION)
THE COLOMBO PLAN
DAP
Drug Advisory Programme

Module 6 Learning Objectives

- Describe the importance of keeping accurate and complete client records
- List five guidelines for effective documentation
- Explain the importance of documentation in the process of screening for treatment eligibility

6.2

Module 6 Learning Objectives

- Explain the SOAP format of progress notes
- Demonstrate writing SOAP notes based on a case study

6.3

Presentation: Essential Forms for Documentation

Essential Forms for a client's file:

- Waiver/ Informed Consent and Release Forms
- Screening Form
- Initial Assessment Form
- Admission Form
- Comprehensive Assessment Form
- Narrative Summary Form
- Treatment Planning (Person-Centered)
- Progress Notes (SOAP Note)
- Continuing Care/Discharge Summary

6.4

Break

15 minutes

6.5

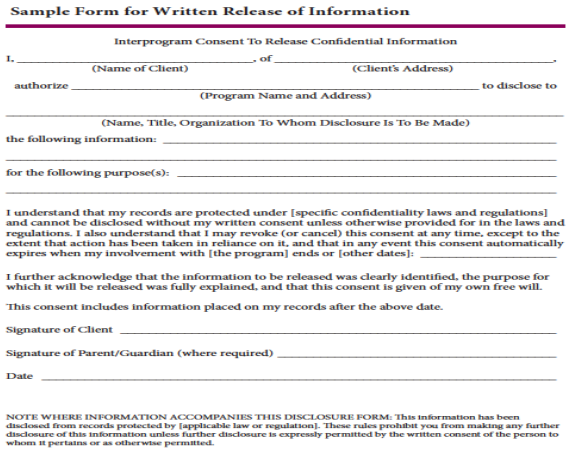
Waiver/Informed Consent

Elements of the consent include:

- Services provided including the Course of Treatment Services and Activities
- Participant Responsibilities
- Participant Rights
- Confidentiality of Records – review the laws and regulations to protect the confidentiality of alcohol and drug use disorder treatment patient records maintained by your organization.
- Release of Information (ROI)
- Assessment Process and Developing a Plan
- Transition and Discharge Criteria
- Access to After Hours Care and Emergency Information

6.6

Waiver/Informed Consent: Release Form



Sample Form for Written Release of Information

Interprogram Consent To Release Confidential Information

I, _____ (Name of Client), of _____ (Client's Address).

authorize _____ (Program Name and Address) to disclose to

_____ (Name, Title, Organization To Whom Disclosure Is To Be Made)

the following information: _____

_____

for the following purpose(s): _____

_____

I understand that my records are protected under [specific confidentiality laws and regulations] and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires when my involvement with [the program] ends or [other dates]: _____

I further acknowledge that the information to be released was clearly identified, the purpose for which it will be released was fully explained, and that this consent is given of my own free will.

This consent includes information placed on my records after the above date.

Signature of Client _____

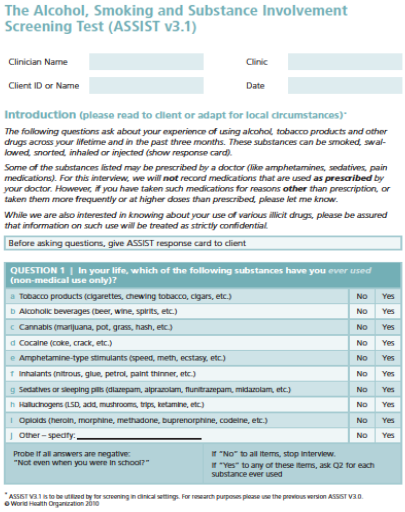
Signature of Parent/Guardian (where required) _____

Date _____

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed from records protected by [applicable law or regulation]. These rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted.

6.7

Screening Form



The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST v3.1)

Clinician Name | Clinic

Client ID or Name | Date

Introduction (please read to client or adapt for local circumstances)*

The following questions ask about your experience of using alcohol, tobacco products and other drugs across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled or injected (show response card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will ***not*** *record medications that are used* ***as prescribed*** *by your doctor. However, if you have taken such medications for reasons* ***other*** *than prescription, or taken them more frequently or at higher doses than prescribed, please let me know.*

While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Before asking questions, give ASSIST response card to client

QUESTION 1 | In your life, which of the following substances have you *ever used* (non-medical use only)?		
a Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	No	Yes
b Alcoholic beverages (beer, wine, spirits, etc.)	No	Yes
c Cannabis (marijuana, pot, grass, hash, etc.)	No	Yes
d Cocaine (coke, crack, etc.)	No	Yes
e Amphetamine-type stimulants (speed, meth, ecstasy, etc.)	No	Yes
f Inhalants (nitrous, glue, petrol, paint thinner, etc.)	No	Yes
g Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)	No	Yes
h Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)	No	Yes
i Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)	No	Yes
j Other – specify: _____	No	Yes

Probe if all answers are negative: "Not even when you were in school?"

If "No" to all items, stop interview.
If "Yes" to any of these items, ask Q2 for each substance ever used

* ASSIST V3.1 is to be utilized by for screening in clinical settings. For research purposes please use the previous version ASSIST V3.0.
© World Health Organization 2010

6.8

Initial Assessment Form

Relevant Medical History

- Current or previous medication
- Allergies
- Basic alcohol and drug history and current use
- Mental Health disorders that are pre-existing, contribute to, or have been exacerbated by substance use
- Family problems that contribute to, or have been exacerbated by substance use
- Any children or other dependents that need care
- Economic Problems that are contributing to, or are exacerbated by substance use:
- Cultural factors which may influence presenting problems
- Education or employment problems that are exacerbated by substance use
- Criminal justice involvement/incidents
- Other issues influencing treatment attendance

6.9

Admission Form

Intake Form

Client's Name: _____ Date: _____

Date of Birth: _____ Marital Status: _____

Home Address: _____

_____

Home Phone_____Work_____E-mail_____

Educational Level: _____ Employment Status: _____

Profession: _____

Insurance: _____

Name of Spouse (if married): _____

Parents: Father's name: _____

Mother' name: _____

Presenting Problem(s):

- Physical _____
- Psychological _____
- Medical _____
- Legal _____
- Social _____

Impression:

_____

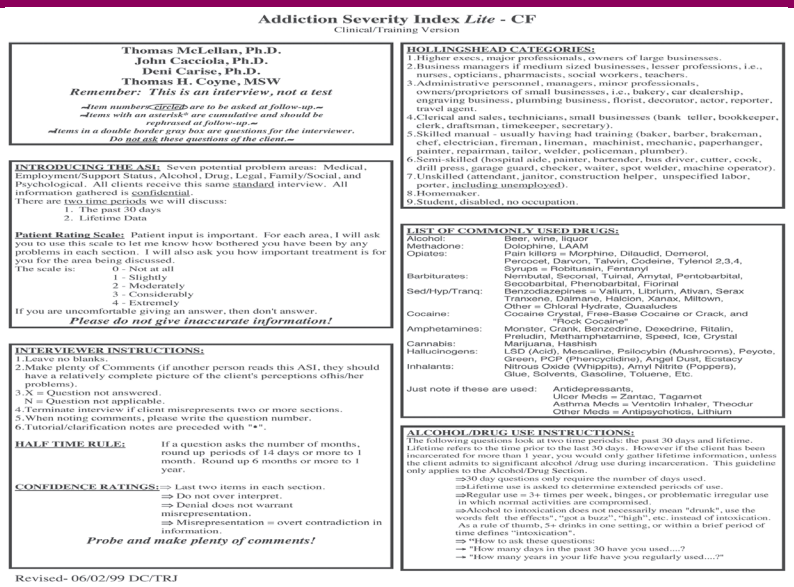
_____

_____

Intake Officer's signature _____ Date: _____

6.10

Comprehensive Assessment Form Tool



Addiction Severity Index *Lite* - CF
Clinical/Training Version

Thomas McLellan, Ph.D.
John Cacciola, Ph.D.
Deni Carise, Ph.D.
Thomas H. Coyne, MSW
Remember: This is an interview, not a test

→Item numbers circled are to be asked at follow-up.←
→Items with an asterisk are cumulative and should be rephrased at follow-up.←*
→Items in a double border gray box are questions for the interviewer. Do not ask these questions of the client.←

INTRODUCING THE ASI: Seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychological. All clients receive this same standard interview. All information gathered is confidential.
There are two time periods we will discuss:
1. The past 30 days
2. Lifetime Data

Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.
The scale is:
0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely
If you are uncomfortable giving an answer, then don't answer.
Please do not give inaccurate information!

INTERVIEWER INSTRUCTIONS:
1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. Tutorial/clarification notes are preceded with "*".

HALF TIME RULE: If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS: ⇒ Last two items in each section.
⇒ Do not over interpret.
⇒ Denial does not warrant misrepresentation.
⇒ Misrepresentation = overt contradiction in information.
Probe and make plenty of comments!

HOLLINGSHEAD CATEGORIES:
1. Higher execs, major professionals, owners of large businesses.
2. Business managers if medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, small businesses (bank teller, bookkeeper, clerk, draftsman, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeman, chef, electrician, fireman, lineman, machinist, mechanic, paperhanger, painter, repairman, tailor, welder, policeman, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Dilaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Synups = Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinal
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate, Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine or Crack, and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Psilocybin (Mushrooms), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstacy
Inhalants:	Nitrous Oxide (Whippits), Amyl Nitrite (Poppers), Glue, Solvents, Gasoline, Toluene, Etc.

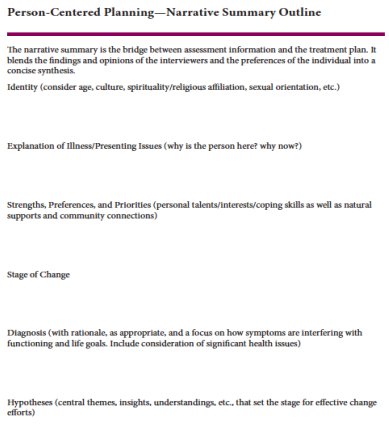
Just note if these are used: Antidepressants,
Ulcer Meds = Zantac, Tagamet
Asthma Meds = Ventolin Inhaler, Theodur
Other Meds = Antipsychotics, Lithium

ALCOHOL/DRUG USE INSTRUCTIONS:
The following questions look at two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days. However if the client has been incarcerated for more than 1 year, you would only gather lifetime information, unless the client admits to significant alcohol /drug use during incarceration. This guideline only applies to the Alcohol/Drug Section.
⇒30 day questions only require the number of days used.
⇒Lifetime use is asked to determine extended periods of use.
⇒Regular use = 3+ times per week, binges, or problematic irregular use in which normal activities are compromised.
⇒Alcohol to intoxication does not necessarily mean "drunk", use the words felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule of thumb, 5+ drinks in one setting, or within a brief period of time defines "intoxication".
⇒ "How to ask these questions:
→ "How many days in the past 30 have you used....?
→ "How many years in your life have you regularly used....?"

Revised- 06/02/99 DC/TRJ

6.11

Narrative Summary Form



Person-Centered Planning—Narrative Summary Outline

The narrative summary is the bridge between assessment information and the treatment plan. It blends the findings and opinions of the interviewers and the preferences of the individual into a concise synthesis.

Identity (consider age, culture, spirituality/religious affiliation, sexual orientation, etc.)

Explanation of Illness/Presenting Issues (why is the person here? why now?)

Strengths, Preferences, and Priorities (personal talents/interests/coping skills as well as natural supports and community connections)

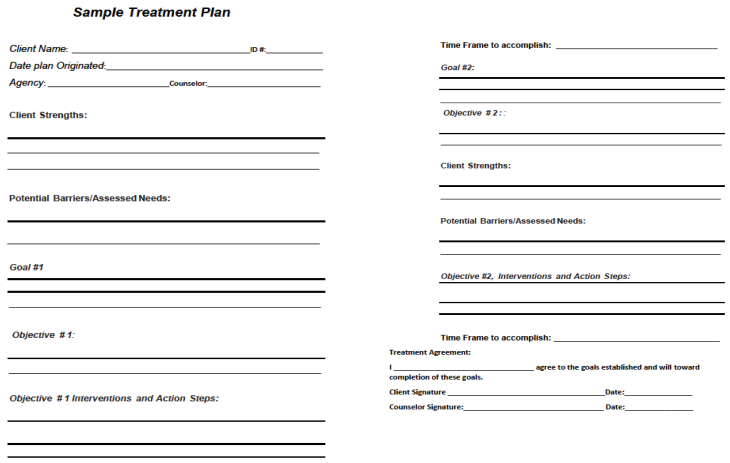
Stage of Change

Diagnosis (with rationale, as appropriate, and a focus on how symptoms are interfering with functioning and life goals. Include consideration of significant health issues)

Hypotheses (central themes, insights, understandings, etc., that set the stage for effective change efforts)

6.12

Treatment Planning Tool



Sample Treatment Plan

Client Name: _____ ID #:_____
*Date plan Originated:*_____
Agency: _____ Counselor:_____

Client Strengths:

Potential Barriers/Assessed Needs:

Goal #1

Objective # 1:

Objective # 1 Interventions and Action Steps:

Time Frame to accomplish: _____

Goal #2:

Objective # 2 : :

Client Strengths:

Potential Barriers/Assessed Needs:

Objective #2, Interventions and Action Steps:

Time Frame to accomplish: _____

Treatment Agreement:

I _____ agree to the goals established and will toward completion of these goals.

Client Signature _____ **Date:**_____

Counselor Signature:_____ **Date:**_____

6.13

Progress notes (SOAP note)

D.A.P PROGRESS NOTE Form

Client : _____ Date: _____

Data

Subjective data: (Client's Observation, thoughts, direct quotes)

Objective data: (Counselor's observation during the session)

Goals and objectives that were discussed during the session

Assignments Completed (or not completed)

ASSESSMENT (Response to treatment, change in the stages of change, results of testing and other tests)

PLAN (Next steps, homework assignments, topics for next session)

6.14

Continuing Care/Discharge form

Sample:

SAMPLE DISCHARGE SUMMARY AND CONTINUING CARE PLAN

Client Name: _____

Date Admitted: _____ Date Discharged: _____

Diagnosis: _____

Primary: _____

Secondary: _____

Reason for Discharge: _____

Summary of Client's progress in meeting the objectives outlined in the treatment plan:

Relate in each objective: Problems/how addressed, results, current needs and supports to meet that need.

Objective 1: _____

Objective 2: _____

Objective 3: _____

Objective 4: _____

Objective 5: _____

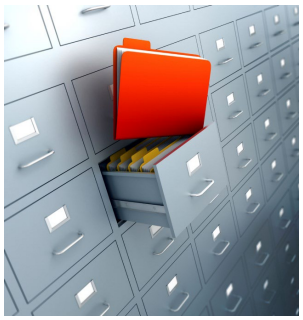
Objective 6: _____

Other Client Needs: _____

6.15

Purposes of Recordkeeping

- Overall purpose: To provide a central file containing information (from a variety of sources) regarding the client's treatment that can be used to enhance care



6.16

Purposes of Recordkeeping

- Documenting screening, assessment, and diagnostic information
- Documenting eligibility and need for treatment
- Tracking a client's progress through treatment

6.17

Purposes of Recordkeeping

- Tracking a client's progress through treatment involves:
  - Documenting changes to a treatment plan
  - Documenting interventions provided
  - Making progress notes
  - Documenting critical incidents
  - Preparing a discharge summary

6.18

Purposes of Recordkeeping

- Communicating about a client to other treatment staff
- Recordkeeping protects the client from misunderstandings and facilitates treatment

6.19

Purposes of Recordkeeping

- Clear and professional documentation is also significant for legal and ethical protection of the agency and the counselor

6.20

Documentation

If it isn't written down, it didn't happen

6.21

Guidelines for Effective Documentation

- Distinguish factual data from opinion or hypothesis
- Be timely
- Write legibly; use correct spelling and grammar
- Never write something that you would be embarrassed for the client or others to read
- Sign and date everything you write

6.22

Documenting Clinical Appropriateness

- Intake, Screening and Initial Assessment help determine whether a program will meet the needs of a particular client
- Programs should offer only treatment services that are reasonable, necessary, and appropriate
- Documenting appropriateness (or lack of appropriateness) of services for a particular client provides accountability and protects a program
- Documentation and registration may vary depending on the requirements and needs of each country or territory.

6.23

Documenting Program Admission:

- As a preliminary process of gathering and sorting out basic information about the client
- On a form specifically designed for the purpose
- Demographic information (Intake Form):
  - Age
  - Gender
  - Where the client lives
  - Employment status (and maybe income level)
- Does the client meet your program's basic criteria?

6.24

Day 4 Wrap-up

6.25

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Treatment of Substance Use Disorders
The Universal Treatment Curriculum for Substance Use Disorders (UTC)
UTC 5
Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals
MODULE 6—RECORDKEEPING (DOCUMENTATION)
THE COLOMBO PLAN
DAP
Drug Advisory Programme

Small-Group Exercise

- Invent a treatment program; write out its admission requirements
- Decide on a method of documenting admission information
- Read your assigned case study
- Using the case study, document the "client's" admission (**or no admission !**) for the treatment program you invented
- Follow the guidelines for effective documentation (slides 6.21 to 6.23)

6.27

Progress Notes

- Must be written after every clinical session or every day for a client in a residential program
- Must contain the date of the session and the length of time of the session
- Must be signed by the author and include credentials
- Some programs have clinical supervisors co-sign progress notes to indicate that they have read them and concur

6.28

SOAP Format of Progress Notes

- Provides a “mini-assessment” each time a note is made
- Ensures that counselors really think about what is going on with a client and what needs to happen next

6.29

SOAP Format of Progress Notes

Subjective

Objective

Assessment

Plan

6.30

Subjective

- Subjective, what belongs to the person and can only be experienced by this person.
- Subjective data: The client's observations, thoughts, direct quotes. Also, may include subjective expressions from the therapist.
- Brief and concise synthesis of what is reported by the client.

6.31

Objective

- Objective data: quantitative and verifiable evidence, such as what can be directly observed through the five senses and scientific measurements
- Include test results or materials from other agencies.
- It is usually done while the conversation with the patient is taking place by observing verbal and non-verbal aspects (affect, mood, appearance)

6.32

Assessment

- The counselor's understanding of the client's current strengths and challenges
- Results of any testing, screening, or assessments
- The client's current response to the treatment plan

6.33

Plan

- Next steps, given the data and assessment results
- Recommended changes, if any, to the treatment plan
- Topics to be discussed in the next session
- Homework assignments

6.34

Guidelines for SOAP Noting

- Record immediately after each session.
- Be brief
- Keep quotes to a minimum
- Use an active voice
- Use precise and descriptive terms

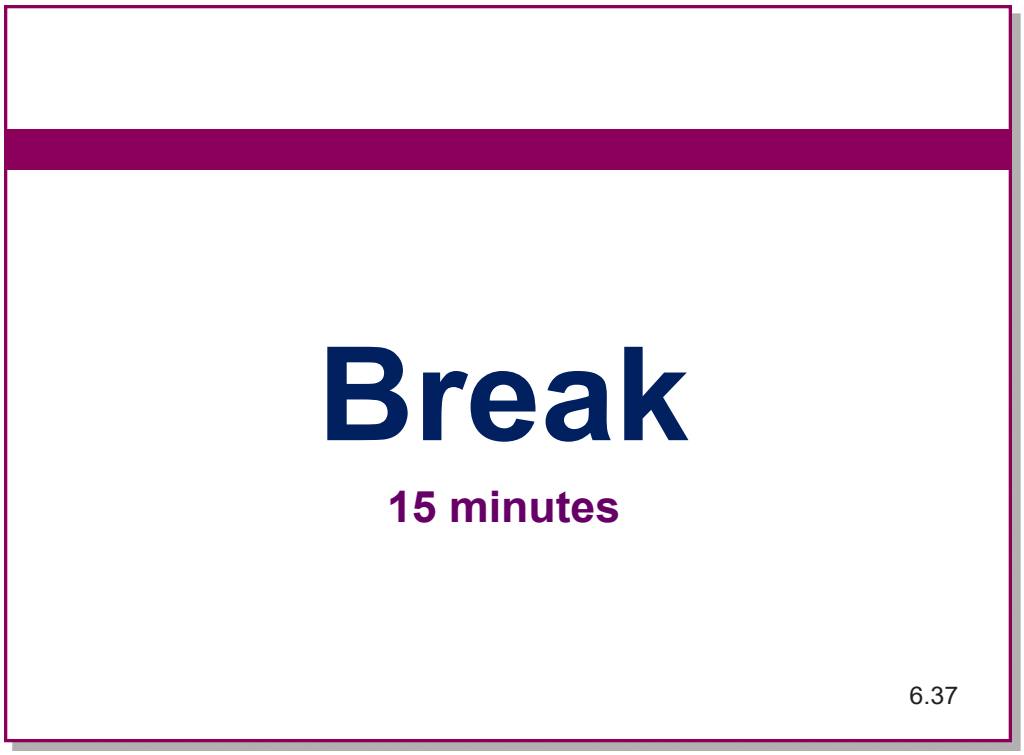
Source: Cameron S. and Turtle-song, I. (2002). 1. Learning to Write Case Note Using the SOAP Format. Journal of Counseling and Development, Vol. 20.
http://www.unm.edu/~clinic/Procedures/Forms/soap%20notes.pdf

6.35

Guidelines for SOAP Noting

- Start each new entry with date and time of session
- Write legibly and neatly
- Use proper spelling, grammar, and punctuation
- Document all contacts or attempted contact
- Use only black ink if notes are handwritten
- Sign-off legal signature, plus your title

6.36


Break
15 minutes
6.37

Small-Group Exercise

- Select one goal in Kanya's treatment plan (Resource Page 6.3)
- Review the objectives and interventions
- Develop the case further by agreeing on a few assumptions regarding the progress Kanya has either made or not made toward achieving that goal
- Pretend you have just met with Kanya and create a progress note using the SOAP format

6.38

Individual Exercise

- Select a goal that is different from the one your group worked with in the previous exercise
- Review the objectives and interventions for that goal
- Develop the case further by adding a few assumptions regarding the progress Kanya has either made or not made toward achieving that goal
- Pretend you have just met with Kanya and create a progress note using the "SOAP" format

6.39

Reflective Exercise

- Write a brief description of the types of documentation used at your agency
- Are they comprehensive enough to meet the needs of the agency?
- Do they protect the well-being of your clients?
- What might you want to do differently?

6.40

Resource Page 6.1: Four Case Studies

Case 1: Kamala

Kamala is a 32-year-old mother of four who has been using cocaine for 3 years. She is unemployed, lost her children (who are now being care for by her parents), appears to be in poor health, and has been using cocaine daily. She started using cocaine regularly because she liked how it made her feel. Now, however, she cannot go a day without it, and it has caused her serious financial problems. She has been accused of stealing from her parents to buy cocaine. She has a history of stormy and passionate relationships with men (three different men are the fathers of her four children) that seem to go back and forth between wild romance and violent arguments. Her lifestyle is chronically chaotic, impulsive, and unstable with regard to both mood and relationships with men. Recently, she has experienced weight loss, insomnia, restlessness, suicidal ideation, and paranoia. She has been living with a man who also abuses drugs. Because of her feelings of sadness and general emptiness, Kamala came into treatment voluntarily (at her parents' insistence). Even though she entered treatment voluntarily, her motivation seems questionable. If she completes treatment, you are concerned about the living environment she would return to.

Case 2: Mohammed

Mohammed is a 25-year-old single male and lives alone. He has been an intermittent drug user for the past 10 years. He came into the screening interview stating that during the last 2 months he has experienced much sadness, difficulty sleeping, a decreased appetite, guilt, and thoughts of suicide. He admits to heavy drug use in the last year, mostly marijuana and amphetamines, but has never before experienced the amount of sadness he now feels. When asked to elaborate, he says that he feels "empty" and that this has occurred nearly every day for at least a month. When asked about other symptoms, he adds that he has also experienced insomnia and lack of appetite frequently during the last month. He also says that he has stopped seeing friends because he has little interest in joining them in some of the activities he used to enjoy, like going to a bar or seeing a movie. He works as a mechanic at a garage but has missed a lot of work; when he is at work, he feels too tired to do much. He is afraid of losing his job. When asked about his drug use, he admits to smoking marijuana daily along with a drinking a few beers and taking amphetamines when he can afford to buy them. He says marijuana helps him escape and the amphetamines make him feel good; when he stops using, he continues to feel sad and empty. When asked about his thoughts of suicide, he says that he does not have a plan but that it would be one way to end the sadness he feels.

Case 3: Rajib

Rajib is a 35-year-old divorced man who came to your clinic at the encouragement of a friend because of both his heroin use and some physical complaints. He admits to using heroin daily and acknowledges that he cannot go a day without it and that it led to his losing his job as a factory worker about a month ago. He says he missed too much work and the company finally fired him. He also lost his apartment because he owes several months' rent and has been temporarily staying with the friend who encouraged him to

get help. He adds that if he does not get his daily fix, his nose runs, he gets stomach cramps, and he feels as if he has "a bad case of the flu." When asked about other physical complaints, he says that he will go into prolonged coughing spells and the only thing that seems to stop them is to light up a cigarette. He also seems to have shortness of breath. He appears to be overweight but mostly in the abdominal area. When asked about his appetite, you realize that he does not have a very healthful diet; he eats irregularly, and when he does it tends to be foods high in sugar.

Case 4: Aditi

Aditi is a 42-year-old married woman and mother of three grown children. She came to treatment at the insistence of her husband. She has a history of cocaine dependence, was successfully treated, and, until about 2 years ago, had gone 10 years without using drugs. Two years ago she was introduced to khat by a friend, and she began chewing it. It gives her a feeling that she used to get from cocaine but was told it is not as harmful, addictive, or expensive. She keeps using it thinking it is harmless, but her use has resulted in several negative consequences. She has experienced an extraordinary amount of tooth decay, has lost her appetite, and appears thin and undernourished. She remains employed as a clerk in a grocery store, but her appearance is of great concern, especially to her husband. Her husband is supportive and, having stayed with her during her cocaine addiction and subsequent treatment, he seems knowledgeable about drug abuse, its effect on families, and what not to do as a family member. Their three children are now grown and seem to have maintained a good relationship with their mother during her recovery. The high she gets from chewing khat is something she really likes, and it seems to take precedence over the physical consequences of her frequent use. She knows that for her own physical well-being and for the sake of her family relationships she needs to stop using.

Resource Page 6.2: Examples of Progress Notes Using the SOAP Format

Example 1

- *Subjective - Client reported feeling depressed since his wife and children left him and he was forced to go into treatment. He stated, "I don't believe in treatment but I am giving it a try as long as it will help bring my wife and children back." He said, "I feel sad and empty when they left. I wanted to talk to my wife."*
- *Objective - Client was withdrawn and guarded. Tearful at times.*
- *Assessment - Overall, client appears uncertain towards treatment. He seems to be depressed. He would benefit from further mental health evaluation.*
- *Plan - Client will continue with the residential treatment program. He agreed to attend at least 1x per week group therapy session. Given ongoing depressive symptoms, will refer for mental health assessment.*

Signed: Mohammad Bakiri, CAC

Example 2

- *Subjective - Client talked about her relationship with her boyfriend, she stated "He yells at me from time to time for no apparent reason." She fears his yelling, saying "I feel afraid everytime he yells at me because he can be violent. I fell hurt when he does that."*
- *Objective - She was anxious and stressed. She was fidgety and talked fast.*
- *Assessment - She appears stressed about her relationship with her boyfriend and continues to be preoccupied with her relationship with him during the visit. Not much improvement has been evident since her last visit.*
- *Plan - Follow-up with healthful relationship material and talk on next session. Continue to work on self-esteem issues.*

Signed: Rupa Costa, LPCC

Resource Page 6.3: Three Possible Treatment Goals—Kanya

Goal #1

"I want to be able to take care of my daughter."

Strengths

Loves her daughter; recognizes need for skill development to manage emotionally charged situations; sister is supportive.

Barriers/Assessed Needs

Frequent arguments with daughter; one instance of slapping daughter; in need of skill development in communication, parenting, and conflict resolution; feeling overwhelmed, stressed, irritable, and tired and experiencing trauma triggers, all of which exacerbate parenting difficulties.

Objective

Kanya will have a minimum of three successful conversations with her daughter by June 14, 2012, as evidenced by her sister's report that Kanya resolved three emotionally charged situations with her daughter without verbal or physical escalation.

Interventions and Action Steps

1. Rupa Costa, Clinician, will meet with Kanya once weekly for the next 3 months to assist her in identifying and managing trauma symptoms that affect her parenting and trigger her angry reactions with her daughter.

2. Mita Sinha, Addiction Counselor, will provide twice monthly anger management group for 3 months to teach Kanya conflict resolution and positive coping strategies to manage stressful situations that arise with her daughter.

3. Megla Dey, Community Liaison, will meet with Kanya twice over the next 2 weeks to help Kanya identify and access parenting-support groups in the community so that she can develop a healthful peer network with which to share her parenting concerns and receive support. In addition, the Community Liaison will assist Kanya in learning about events/activities in the community that Kanya and her daughter could attend together.

4. Within 2 weeks, Kanya will develop a list of preferred activities she'd like to engage in with her daughter to increase the amount of enjoyable time they spend together.

5. Kanya's sister will participate in the treatment center's family psychoeducation program to receive education about the relationship among substance use, trauma, and depression.

Goal #2

"I just want to sleep through the night without using marijuana."

Strengths

In a safe, stable living situation; beginning to understand the relationship among substance use, trauma, depression, and sleep disturbance; positive relationship with addiction counselor, who offers healthful relaxation group.

Barriers

Vivid nightmares wake Kanya up repeatedly throughout the night; she has not slept through the night in months; tends to resort to use of marijuana to relax, sleep, and relieve distress caused by nightmares.

Objective 1

By July 14, 2012, Kanya will report at least 2 nights per week of uninterrupted sleep (minimum of 7 hours) for 3 consecutive weeks in which she does not wake up from nightmares.

Interventions and Action Steps

1. Rupa Costa, Clinician, will provide supportive counseling once weekly for the next 3 months to assist Kanya in identifying and managing symptoms of trauma and depression that lead to nightmares and sleep disturbance.
2. Mita Sinha, Addiction Counselor, will provide once weekly sleep and wellness group for the next 3 months to improve sleep habits/patterns.
3. Kanya's sister will go with Kanya to the health clinic in the next 2 weeks to get a physical to identify any health problems, including those that may contribute to her sleeping problems.
4. Kanya will teach her sister her preferred relaxation strategies, and they will do them together before bed for the next 2 weeks.

Objective 2

Kanya will maintain abstinence for the next 3 months as evidenced by biweekly urine screens collected by her addiction counselor.

Interventions and Action Steps

Mita Sinha, Addiction Counselor, will provide a once weekly recovery practices group to teach Kanya positive coping skills to deal with cravings and manage stressors/symptoms without substance use.

Kanya will attend a minimum of three local Alcoholics Anonymous/Narcotics Anonymous groups within 2 weeks to explore whether a 12-Step program can be a helpful source of support in learning positive ways to manage stressors and sleep disturbance without marijuana use.

Goal #3

"I'd like to get a job."

Strengths

Recognizes need for steady employment; natural ability making things with her hands; sister is employed as an artisan making handicrafts.

Barriers/Assessed Needs

Symptoms of trauma, depression, and substance use have contributed to Kanya's lack of stable employment. She is uncertain that she can keep a job because of her frequent irritability and feeling overwhelmed and tired.

Objectives

- By May 14, 2012, Kanya will have a written list of how work will change her life (what expectations she will have to meet and what she can expect to get from a steady job).
- By June 14, 2012, Kanya, with staff assistance, will demonstrate her ability to respond to difficult situations that may come up on the job.
- By August 14, 2012, Kanya will interview for at least three jobs.

Interventions and Action Steps

1. Robin Reza, M.D., to provide medication evaluation and monitoring twice a month for the next 3 months.
2. Sumon Khan, Employment Coordinator, to provide skill assessment and skill building once a week for the next 6 months to build confidence and skills in interviewing for a job and managing possible difficulties on the job. Employment Coordinator will provide counseling on expectations of employers and what Kanya can expect to get from steady employment. Employment Coordinator will provide instruction in interviewing and managing possible difficulties that may come up in the interview and on the job.
3. Kanya's sister has agreed, within the next 6 months, to help collect information from at least six friends about where they work, what they do, what their co-workers and work culture are like, and what job opportunities are available there.

Module 6 – Recordkeeping (Documentation), Summary

Essential forms for documentation

- The essential documents that need to be included in a client's file are:
  - Waiver/ Informed Consent and Release Forms
  - Screening Form
  - Initial Assessment Form
  - Admission Form
  - Comprehensive Assessment Form
  - Narrative Summary Form
  - Treatment Planning (Person-Centered)
  - Progress Notes (SOAP Note)
  - Continuing Care/Discharge Summary
- Please note that many countries and services will have their own standards and reporting or documentation requirements. This includes what screening, comprehensive assessment and record keeping is required - and that practitioners should find out what they are required to do in their country and according to their specific service system.

Waiver/Informed Consent

- Elements of an Informed Consent include:
  - Services provided, including the Course of Treatment Services and Activities that the person will be provided and any payment for the services
  - Participant Responsibilities- for example to file a grievance
  - Participant Rights- for example –
    - To receive treatment and other program services in quantity and quality that is unaffected by your race, sex, creed, color, handicap, or national origin.
    - To receive services in an environment free of verbal harassment, bullying, teasing, stalking, domestic violence, racism, sexism, financial or other exploitation, retaliation, humiliation, neglect or sexual abuse.
- Confidentiality of Records – review the laws and regulations to protect the confidentiality of alcohol and drug use disorder treatment patient records maintained by your organization.

- Generally, to not say to a person outside the program that a patient attends the program, or disclose any information identifying the patient as an alcohol or drug use disorder treatment patient unless: (1) The patient consents in writing; OR (2) The disclosure is allowed by a court order; OR (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for supervision or program evaluation; OR (4) The patient commits or threatens to commit a crime either at the program or against any person who works for the program; OR (5) In the case of communicable disease reporting; OR (6) In the case of child abuse or neglect or elderly abuse reporting; OR (7) In the case of harm or injury to self or others; OR (8) In the case of third part payers; OR (9) An investigation relating to patient's death.
- Release of Information (ROI)- Receiving or sharing personal information about you from records with any other party will require your written consent and the process needs to be explained
- Assessment Process and Developing a Plan
- Transition and Discharge Criteria
- Access to After Hours Care and Emergency Information

Waiver/Informed Consent: Release Form

- There are times that a release of information is required. The client's family, attorney or employer may have a need to know how the client is responding to treatment.
- The signing of a specific release of information will allow the disclosure of information that is very specific to the need. It is important to understand the signature of this document both in its legal and ethical dimensions. Regarding the latter, the person freely, voluntarily and informed agrees that the treatment program provide specific information regarding its process. It is the duty of the professional team to ensure that the delivery of this information is carried out under strict ethical standards (confidentiality, specific information for a specific purpose and that the person is always informed prior to the delivery of this information).
- Informed consent should not be considered an authorization for the unlimited or permanent release of information.

Flow of Forms Screening

- The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed under the auspices of the World Health Organisation (WHO) by an international group of addiction researchers and clinicians in response to the overwhelming public health burden associated with psychoactive substance use worldwide. It was designed to be used in primary health care settings where hazardous and harmful substance use among clients may go undetected or become worse. The ASSIST (version 3.1) is an 8-item questionnaire designed to be administered by a health worker to a client using paper and pencil and takes about 5-10 minutes to administer. The ASSIST was designed to be culturally neutral and useable across a variety of cultures to screen for use of the following

substances: tobacco products, alcohol, cannabis, cocaine, amphetamine type stimulants (ATS), sedatives and sleeping pills (benzodiazepines), hallucinogens, inhalants, opioids, and 'other' drugs.

- The ASSIST determines a risk score for each of these substances which is then used to start a discussion (brief intervention) with clients about their substance use. The score obtained for each substance falls into a 'lower ', 'moderate' or 'high' risk category which determines the most appropriate intervention for that level of use ('no treatment', 'brief intervention' or 'referral to specialist assessment and treatment' respectively).
- The ASSIST obtains information from clients about lifetime use of substances, and use of substances and associated problems over the last 3 months. It can identify a range of problems associated with substance use including acute intoxication, regular use, dependent or 'high risk' use and injecting behavior. It is thus an essential document that needs to be included in the client file.
- A screening form can also include all eligibility criteria for treatment admission such as age, ability to pay for treatment and if there is a geography constraint (must be from a certain country or part of the country), etc.
- While this information was presented earlier, remember that this module is about documentation. These are ideas about what to document that can be helpful before the initial comprehensive assessment is completed.
- This type of information in an initial form can help identify a participant's treatment needs but it is the responsibility of staff to gather additional information on the following items in a comprehensive assessment that includes in depth information about social, economic and family history, education, employment history, criminal history, legal status, medical history, alcohol and/or other drug history, and previous treatment.
- The topics include but the items should not duplicate what will be collected in the comprehensive assessment.
    - Current or previous medication
    - Allergies
    - Basic alcohol and drug history and current use
    - Mental Health disorders that are pre-existing, contribute to or have been exacerbated by substance use
    - Family problems that contribute to or have been exacerbated by substance use
    - Economic problems that are contributing to, or are exacerbated by substance use:
    - Cultural factors which may influence presenting problems: (e.g., ethnicity, race religion, spiritual practice, sexual orientation, gender identity, socioeconomic status, living environment, etc.)
    - Education or employment problems that are exacerbated by substance use:

- Criminal justice involvement/incidents
- Transportation or other issues influencing treatment attendance.

Admission Form

- You can use any use tool for initial assessment that has acceptable measurement properties such as high degrees of reliability and validity.

Comprehensive Assessment Form Tool.

- The Addiction Severity Index, Lite version (ASI-Lite) is a shortened version of the Addiction Severity Index (ASI). The ASI is a semi-structured instrument used in face-to face interviews conducted by clinicians, researchers or trained technicians.
- The ASI covers the following areas: medical, employment/support, drug and alcohol use, legal, family/social, and psychiatric. The ASI obtains lifetime information about problem behaviors, as well as problems within the previous 30 days.
- The ASI-Lite contains fewer questions than the ASI, and omits items relating to severity ratings, and a family history grid. Remember that you can add questions to it, if needed. You should not remove the essential questions noted on the form

Narrative Summary Form

- The narrative summary is a bridge between the assessment and the plan.
- The narrative summary is the counselor's impression of what is going on with the client, an understanding about who this person is.
- The term "narrative" is used to emphasize that the summary is based in the counselor's words and is used to justify the treatment being recommended.

Treatment Planning Tool

- We use the person-centered treatment plan to document treatment goals and objectives with our clients and set them in order of priority. This helps to keep the focus on the client's goals in treatment.

Progress notes (SOAP note)

- It is important to have a document to record what is reported by your client and your impressions of the interactions between you and the client. The SOAP Note does that for us. As we have seen earlier in this module, it summarizes the important points of each client visit.

Continuing Care/Discharge form

- The continuing care/discharge summary document is used to document the plan of sustained recovery as well as what the client may desire to continue to work on.

- As a client transitions from one level of care to another (residential to out-patient) or has completed treatment, this document will serve as a guide for his or her continuing recovery.

Purposes of record keeping

- Record keeping is a critical process in the treatment of substance use disorders.
- Overall, the purpose of recordkeeping is to provide a central file containing information (from a variety of sources) regarding the client's treatment that can be used to enhance client care.
- Recordkeeping is a means of:
  - Documenting screening, assessment, and diagnostic information; and,
  - Documenting a client's eligibility and need for treatment.
  - Tracking a client's progress through treatment

Tracking a client's progress through treatment involves:

- Documenting changes to a treatment plan;
- Documenting interventions provided;
- Documenting a client's progress in treatment (progress notes), including the impact of interventions;
- Documenting critical incidents; and,
- Preparing a discharge summary.

- Record keeping is a means of communicating with other treatment staff members so that everyone knows what is going on with a client. It helps protect the client from misunderstandings and facilitates his or her progress through treatment.
- Clear and professional documentation is also significant for legal and ethical protection of the program and the counselor.
- In a real sense, "If it isn't written down, it didn't happen." The written record is the only way others know what you did, what your thinking was for your clinical decision-making and shows how things happened.

Guidelines for Effective Documentation

- No matter the type of record keeping, there are five important guidelines for effective documentation:

1. Factual data and objective observations must be clearly distinguished from opinion. Counselors must be careful to write an objective summary of the client's activities and progress (or lack of progress) toward goals. As we discussed in Module 5, counselors do form hypotheses about clients' behavior, but these must be stated

as such. For example: "In my opinion…," "I am wondering whether…," "Based on this behavior, it is possible that…," and so on.

2. Documentation must be timely. Events and activities must be documented when they occur, not the next day, week, or month! Relying on memory is poor practice.

3. Documentation must be legible with correct spelling and use of grammar. Remember, client records will be read by current treatment staff members and may be read by a future treatment team. For example, staff members will need to read treatment notes if a client returns for treatment or if records are released (with client's permission) to another program where the client is treated in the future.

4. You should never write something that you would be embarrassed for the client to read or would be embarrassed to have read in public (in a courtroom, for example). Always assume that at some point the client will see what you have written.

5. Finally, all documentation must be signed and dated.

- The information you collect during screening and intake will help you determine whether your program will meet the needs of a particular client. Programs should offer only treatment services that are reasonable, necessary, and appropriate for the diagnosis and treatment of a particular disorder (or level of severity of the illness). Documenting the appropriateness (or lack of appropriateness) of your services for a particular client provides accountability and protects your program.
- The client data help a program determine the appropriateness of treatment services for a client.
- In documenting program admission, you would need to know basic demographic data such as: Age; Gender; Where the client lives; and Employment status (and maybe income level).
- You need to find out whether the client meets your program's basic criteria. This information should be documented before you do an initial assessment.
- For example:
  - If your program serves only adolescents, is the client within the age range of clients you will accept?
  - Where does the client live? Is the client within the geographical boundaries your program serves?
  - Does the client work? Can the client pay for the services? Or, if your program has sliding fee scales, is the client's income within range?
- So, we've talked about why we document treatment eligibility information and what kinds of information that is. Now we need to talk about how this treatment eligibility information is documented.

Progress notes SOAP note format

- A progress note needs to be made after every clinical session or every day for a client in a residential program.
- Progress notes must contain the date of the session and the length of time of the session.
- Progress notes must be signed by the author and have the author's credentials clearly documented.
- Some programs have clinical supervisors co-sign progress notes to indicate that they have read them and concur.
- As you can see, there are different methods of documenting clients' progress. We are going to a closer look a closer look at one form of writing progress notes: The SOAP format.
- We're using this model because it actually provides a "mini-assessment" each time a note is made, ensuring that counselors really think about what is going on with a client and what needs to happen next.
- There are four components of the SOAP notes:

  1. Subjective
  2. Objective
  3. Assessment, and,
  4. Plan.

- The data collection is divided into two parts: Subjective and Objective. First will address the subjective data.

  - The Subjective component - contains information about the problem from the client's perspective and that of significant others. It includes:
  - Subjective data, such as the client's feelings, concerns, plans, goals, and thoughts, plus the intensity of the problem and its impact on significant relationships in the client's life are recorded. Pertinent comments supplied by family members, friends, and so forth, can also be included in this section.
  - The subjective entry should be as brief and concise as possible. If and when quotations are used, the counselor should record only key words or a very brief phrase. The counselor should simply write, "reports, states, says, describes, complains of," and so on. Example, the counselor might write, "client reports decreased drug use after last session."

Subjective

- The term "subjective" indicates what belongs to the subject and can only be experienced by this person. For example: The client refers to feeling sad and desperate, because he can't get a job. It is essential to understand how the person experiences a certain situation, the beliefs associated with a specific experience, and the experiences of physical and mental pain.
- The registration, assessment and legitimation of this subjective information is important not only in ethical terms, but it also facilitates the construction of a therapeutic alliance and can provide a number of indicators in the recovery process of a person.

Objective

- The next component of the SAP format is the objective data. This component should be factual. It is written in quantifiable terms - that which can be seen, heard, smelled, counted or measured.
- It refers to counselor's observations that include physical appearance, affect, behavior and client's strengths. It can include test results or materials from other agencies.
- In this component:
  - Avoid labels, personal judgments, value-laden language, or opinionated statements;
  - Words that may have a negative connotation, such as "uncooperative", "manipulative," "abusive" and "drunk" are open for personal interpretation. For example, "Client stood up with clenched fist and jaw, angrily stated that counseling is not working. Walked out from the counseling room."
- Objective data might include the counselor's observations during the session (affect, mood, appearance) and may include test results or materials from other agencies. This objective information includes quantitative and verifiable evidence, such as what can be directly observed through the five senses and scientific measurements. This can include the patient's appearance, any medical measures taken, and obvious behavior.
- Objective data is description; but not personal interpretation, rather, it is a description of reactions or behaviors observed by the counselor.
- A discussion of the term objectivity can be very interesting. The counselor's observations are in one sense subjective interpretations about the client. From this dual perspective, objective reality is also subjective because even though we experience objects as separate from us, all that is said is said by an observer, and what is said cannot be separated from the subject!

Assessment

- The assessment component of SOAP summarizes the relevant points from the subjective and objective data sections. It can include the counselor's understanding of the client's current strengths and challenges, the results of any testing, screening, or assessments, and the client's current response to the treatment plan. The assessment component can also note any changes in the client's stage of change.

- Examples of what might be included in this component are:
  - "Needs referral to mental health specialist for evaluation" or "Beginning to own responsibility or consequences related to drug use."

Plan

- The plan component of the SOAP format is the counselor's (along with the client's) answer to "What's next?" given the data and assessment results.
- This component includes:
  - Recommended changes, if any, to the treatment plan (these need to be mutually agreeable to the counselor and the client); Example, "Refer to mental health specialist for evaluation."
  - Topics to be discussed in the next session; and,
  - Homework assignments; Note that the client's literacy and ability work on the assignments should be considered. An example of a homework assignment might be," Reading the handout on understanding addictions and its consequences."

Guidelines for SOAP Noting

- To ensure both the quality and accuracy of the notes and to safeguard the integrity of the counselor, the following guidelines should be observed when writing the SOAP note.
- Record the session immediately after the session while it is still fresh in your mind. This avoids the uncertainty, confusion, errors, or inaccuracies that are most likely to occur when you try to complete all the files at the day's end. Be brief, keep quotes to a minimum, and use an active voice, and use precise and descriptive terms.[31]
- Start each new entry with date (day, month, and year) and time the session began. Make each entry legible and neat, with no grammar, spelling, or punctuation errors.
- All client contacts or attempted contact should be recorded using the SOAP format. This includes telephone calls, messages left on answering machines, messages left with individuals who answered the phones, letters, emails and SMS. (Text messages). Letters that were mailed to the client would be noted in the record along with a copy of the signed letter.
- When recording a session, keep in mind that altered entries arouse suspicions and can create significant problems for the counselor in the court of law (Norris, 1995). If an error is made, never erase, obliterate, use correction fluid, or in any way obscure the mistake. Instead, the error should be noted by enclosing it in brackets, drawing

[31]Cameron S. and Turtle-song, I. (2002). 1. Learning to Write Case Note Using the SOAP Format. Journal of Counseling and Development, Vol. 20.http://www.unm.edu/~clinic/Procedures/Forms/soap%20notes.pdf

a single line through the incorrect word (s), and writing the word "error" above or to the side of mistake. Follow this correction with your initials, full date, and time of correction. The mistake should still be readable, indicating your attempt to clarify the mistake and not cover it up.

- If not typed, all entries should be written in black ballpoint pen, which allows for easy photocopying should the file be requested at a later date. Furthermore, notes should never be written in pencil or felt-tipped pen because pencil can be easily erased or altered, whereas felt-tipped pen is easily smudged or distorted should something spill on the notes.
- At the conclusion of the entry, you need to sign off using legal name- generally considered to be the first initial and last name followed by your title.
- There should be no empty space between the content of the SOAP notes and the signature. Blank spaces may later be interpreted to mean that there is missing information or that the counselor failed to provide "complete care; even worse, empty spaces can be filled up by another person without your knowledge.

MODULE 7

RECORDKEEPING (DOCUMENTATION)

Content and Timeline 431
Training goals and learning objectives 431
Resource pages 432
Summary 433

Content and Timeline	
Activity	***Time***
Introduction to Module 7	5 minutes
Small Group Exercise- Developing practice integration plan	30 minutes
Partner Exercise- Sharing your practice integration plan	10 minutes
Course wrap-up, learning assessment, evaluation and program completion	40 minutes
Overall training evaluations and Program Completion	45 minutes
End of day 5	

Module 7 Goals and Objective

Training goals

- To encourage participants to think about resources, barriers, and strategies for change; and,
- To provide an opportunity to develop a personal practice integration plan.

Learning objective

Participants who complete Module 7 will have developed a personal practice integration plan.

Resource Page 7.1: Practice Integration Plan

1. The most important thing I learned from this training, and don't want to forget, is:

_____

_____

_____

2. Changes I will make in my practice based on what I have learned are:

_____

_____

_____

3. Some things that could interfere with my plans are (e.g., anticipated barriers):

_____

_____

_____

4. Ways I could overcome these barriers include:

_____

_____

_____

5. The following people (include supervisors, potential mentors, and so on) and resources (further training, reading) could help me in the following ways:

Person or Resource	***Possible Ways To Help***

Module 7—Recordkeeping (Documentation), Summary

Effective documentation

- Treatment planning is one form of documentation of the client's treatment experience.
- Documentation, or recordkeeping, also involves recording screening, intake, and assessment information as well as maintaining an ongoing record of the client's care.
- Recordkeeping is a critical process in the treatment of substance use disorders.
- Overall, the purpose of recordkeeping is to provide a central file containing information (from a variety of sources) regarding the client's treatment that can be used to enhance client care.
- Recordkeeping is a means of:
  - Documenting screening, assessment, and diagnostic information;
  - Documenting a client's eligibility and need for treatment; and
  - Tracking a client's progress through treatment.
- Tracking a client's progress through treatment involves:
  - Documenting changes to a treatment plan;
  - Documenting interventions provided;
  - Documenting a client's progress in treatment (progress notes), including the impact of interventions;
  - Documenting critical incidents; and
  - Preparing a discharge summary.
- Recordkeeping is a means of communicating with other treatment staff members so that everyone knows what is going on with a client. It helps protect the client from misunderstandings and facilitates his or her progress through treatment.
- Clear and professional documentation is also significant for legal and ethical protection of the program and the counselor.
- In a real sense, "If it isn't written down, it didn't happen."
- There are five important guidelines for effective documentation:
  1. Factual data and objective observations must be clearly distinguished from opinion. Counselors must be careful to write an objective summary of the client's activities and progress (or lack of progress) toward goals. When counselors form hypotheses about clients' behavior, the hypotheses must be stated as such. For example: "In my opinion…," "I am wondering whether…," "Based on this behavior, it is possible that…," and so on.

2. Documentation must be timely. Events and activities must be documented when they occur, not the next day, week, or month! Relying on memory is poor practice.
3. Documentation must be legible with correct spelling and use of grammar. Remember, client records will be read by current treatment staff members and may be read by a future treatment team. For example, staff members will need to read treatment notes if a client returns for treatment or if records are released (with client's permission) to another program where the client is treated in the future.
4. Documentation should never include something that would embarrass the client or that would be embarrassing to have read in public (in a courtroom, for example). Always assume that at some point the client will see what you have written.
5. All documentation must be signed and dated.

- There are several types of documentation:
  - Screening, using the Alcohol, Smoking and Substance Involvement Screening Test;
  - Initial assessment, using the Addiction Severity Index;
  - Narrative summaries; and
  - Initial treatment planning.

Documenting client eligibility for treatment

- Documentation helps determine a client's eligibility for a program. For example:
  - Screening with the ASSIST can indicate whether a client needs treatment; and
  - Initial assessment with the ASI and the narrative summary can provide information indicating what type and level of treatment a client may need.
- The information collected during screening and intake helps determine whether the program will meet the needs of a particular client.
- Programs should offer only treatment services that are reasonable, necessary, and appropriate for the diagnosis and treatment of a particular disorder (or level of severity of the illness).
- Documenting the appropriateness (or lack of appropriateness) of services for a particular client provides accountability and protects the program. For example:
  - Documenting program appropriateness assures the client, the client's family, and outside observers (such as program monitors or even a client's attorney) that the program is acting in the best interest of the client and not, for example, simply trying to make money;
  - Documenting program inappropriateness provides a clear rationale for not accepting a client and making a referral; and

- Documenting both appropriateness and inappropriateness ensures that a program is not operating beyond its scope of competency (for example, accepting a client with a severe mental disorder the program is unprepared to treat).

- Along with clinical data, other factors that help a program determine the appropriateness of treatment services for a client include:
  - The client's age;
  - The client's gender;
  - Where the client lives; and
  - The client's employment status (and maybe income level).
- The counselor needs to find out whether the client meets the program's basic criteria. This information should be documented before the counselor completes the initial assessment. For example:
  - If the program serves only adolescents, is the client within the acceptable age range?
  - Where does the client live? Is the client within the geographical boundaries that the program serves?
  - Does the client work? Can the client pay for the services? Or, if the program has sliding fee scales, is the client's income within range?
- Information can be documented in a number of ways:
  - As a specific part of a narrative summary;
  - As an initial progress note; or
  - On a form specifically designed for the purpose of documentation.
- The important thing is that information is documented and that it is done in a consistent manner.

Progress notes—The SOAP format

- A progress note needs to be made after every clinical session or every day for a client in a residential program.
- Progress notes must contain the date of the session and the length of time of the session.
- Progress notes must be signed by the author and have the author's credentials clearly documented. Some programs have clinical supervisors co-sign progress notes to indicate that they have read them and concur with what the counselor has written.
- There are different methods of documenting clients' progress.

- One particular method is the SOAP format. This method provides a "miniassessment" each time a note is made, ensuring that counselors really think about what is going on with a client and what needs to happen next.
- In English, SOAP is an acronym for:
  - Subjective ;
  - Objective;
  - Assessment; and,
  - Plan.
- Subjective component - contains information about the problem from the client's perspective and that of significant others. The client's feelings, concerns, plans, goals, and thoughts, plus the intensity of the problem and it's impact on significant relationships in the client's life are recorder. Pertinent comments supplied by family members, friends, and so forth, can also be included in this section.
- The entry should be as brief as brief and concise as possible.
- If and when quotations are used, the counselor should record only key words or a very brief phrase.
  - The counselor should simply write, "reports, states, says, describes,complains of," and so on. Example, the counselor might write, "client reports decreased drug use after last session."
- Objective component - should be factual. It is written in quantifiable terms - that which can be seen, heard, smelled, counted or measured.
- Refers to counselor's observations that include physical appearance, affect, behavior. and client's strengths.
- Include test results or materials form other agencies.
- Avoid labels, personal judgments, value-laden language, or opinionated statements. Words that may have a negative connotation, such as "uncooperative", "manipulative",, "abusive" and "drunk" are open for personal interpretation.
- Example, "Client stood up with clenched fist and jaw, angrily stated that counseling is not working. Walked out from the counseling room."

The Assessment component - summarizes the relevant points from the data sections, Subjective and Objective components.

- The counselor's understanding of the client's current strengths and challenges.
- Results of any testing, screening, or assessments.
- The client's current response to the treatment plan.

- Any changes in the client's stage of change.
- Example: " Needs referral to mental specialist for evaluation." Here is another example, "Beginning to own responsibility or consequences related to drug use."

The Plan component of this format is the counselor's (along with the client's) answer to "what's next?", given the data and assessment results. These are the

- Recommended changes, if any, to the treatment plan (these need to be mutually agreeable to the counselor and the client);
- Topics to be discussed in the next session; and,
- Homework assignments.
    - Example, " Refer to mental health specialist for evaluation." Here s an example of a homework assignment, "Reading the handout on understanding addiction and its consequences. "

Guidelines for SOAP Noting

To ensure both the quality and accuracy of the notes and to safeguard the integrity of the counselor, the following guidelines should be observed when writing the SOAP notes[1].

Record the session immediately after the session while it is still fresh in your mind. This avoids the uncertainty, confusion, errors, or inaccuracies that are most likely to occur when you try to complete all the files at the day's end. Be brief, keep quotes to a minimum, use an active voice, and use precise and descriptive terms.

Start each new entry with date (day, month, and year) and time the session began. Make each entry legible and neat, with no grammar, spelling, or punctuation errors.

All client contacts or attempted contact should be recorded using the SOAP format. This includes telephone calls, messages left on answering machines, messages left with individuals who answered the phones, letters, emails and SMS. (text messages). Letters that were mailed to the client would be noted in the record along with a copy of the signed letter.

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Resource Page 8.1: Practice Integration Plan

1. The most important thing I learned from this training, and don't want to forget, is:

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2. Changes I will make in my practice based on what I have learned are:

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3. Some things that could interfere with my plans are (e.g., anticipated barriers):

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4. Ways I could overcome these barriers include:

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5. The following people (include supervisors, potential mentors, and so on) and resources (further training, reading) could help me in the following ways:

Person or Resource	***Possible Ways To Help***

APPENDIX A—GLOSSARY

SOAP format	A way of writing progress notes that provides a "mini assessment" each time a note is made, ensuring that counselors really think about what is going on with a client and what needs to happen next.
functional analysis	A process of seeking to understand what roles or functions substance use is playing in a person's life. Understanding the role substance use plays in a person's life begins in the initial assessment and unfolds throughout treatment.
informed consent	A client's consent for treatment that is given with full knowledge of the risks involved, probable consequences, and the alternatives. It includes knowledge of the limitations of confidentiality.
narrative summary	An impression of what is going on with a person and an understanding about who this person is. The narrative summary is a bridge between the assessment and the treatment plan.
person-centered approach	An approach that empowers a person to be an active and knowledgeable partner in his or her own recovery process. The person identifies how treatment will help him or her live a personally meaningful life (i.e., the goal).
recovery	"[A] process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential."[2]
recovery capital	"[T]he sum of personal and social resources at one's disposal for addressing drug dependence and, chiefly, bolstering one's capacity and opportunities for recovery."[1]
recovery-oriented system of care	A coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.[2]

[1] White, W. (2009). Executive summary. Peer-based addiction recovery support: History, theory, practice, and scientific evaluation. *Counselor, 10*(5), 54–59.
[2] SAMHSA Blog. (2011, May 20). Retrieved July 5, 2012, from http://blog.samhsa.gov/2011/05/20/recovery-defined-a-unified-working-definition-and-set-of-principles/

APPENDIX B—RESOURCES

Global Drug Use Statistics

United Nations Office on Drugs and Crime. (2020). *World drug report 2020.* New York: United Nations.

World Health Organization. (2010). *Management of substance abuse: The global burden.* Geneva: Author. Retrieved December 10, 2010, from http://www.who.int/substance_abuse/facts/global_burden/en/index.html

World Health Organization. (2011). *Management of substance abuse: Facts and figures.* Geneva: Author. Retrieved December 10, 2010, from http://www.who.int/substance_abuse/facts/en/

Welcoming Environment

NIATx (formerly known as the Network for the Improvement of Addiction Treatment) http://www.niatx.net

Cameron S. and Turtle-song, I. (2002). 1. Learning to Write Case Note Using the SOAP Format. Journal of Counseling and Development, Vol. 20. Retrieved at http://www.unm.edu/~clinic/Procedures/Forms/soap%20notes.pdf on 25 May 2015.

Adams, N and Grieder, D (2005). Treatment planning for person-centered care: The road to mental health and recovery. Elsezier Academic Press. MA. USA

Role of the Counselor

Martino, S., Ball, S. A., Gallon, S. L., Hall, D., Garcia, M., Ceperich, S., et al. (2006). *Motivational interviewing assessment: Supervisory tools for enhancing proficiency.* Salem, OR: Northwest Frontier Addiction Technology Transfer Center, Oregon Health and Science University. http://www.motivationalinterview.org/Documents/MIA-STEP.pdf

Miller, W. R., Forcehimes, A. A., & Zweben, A. (2011). *Treating addiction: A guide for professionals.* New York, Guilford Press.

UNODC. WHO. (2008). *Principles of drug dependence treatment.* New York: United Nations. http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf

U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). (2003). *Action planning for prevention and recovery.* Rockville, MD: Author. http://store.samhsa.gov/shin/content//SMA-3720/SMA-3720.pdf.

Screening and Assessment Instruments

Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001). *The Alcohol Use Disorders Identification Test: Guidelines for use in primary care*, 2nd ed. Geneva: WHO Press.

Treatment Research Institute. Publications and manuals on and versions of the Addiction Severity Index
http://www.tresearch.org/resources/instruments.htm#top

WHO. Publications and manuals on and versions of the Alcohol, Smoking and Substance Involvement Screening Test
http://www.who.int/substance_abuse/activities/assist/en/index.html

http://ctndisseminationlibrary.org/PDF/88endmaterial.pdf retrieved on 15 June 2015

Treatment Planning

Adams, N., & Grieder, D. (2004). *Treatment planning for person-centered care: The road to mental health and addiction recovery* (Practical Resources for the Mental Health Professional Series). London: Elsevier Academic Press.

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Riza Sarasvita, Ph.D.
Chief of Substance Abuse Subdirectorate
Ministry of Health
Indonesia

Miriam Cue, Ph.D.
Chairperson
Professional Regulatory Board of Psychology
Professional Regulation Commission
Philippines

Ma. Veronica Felipe
Director (Former)
Drug Advisory Programme - Colombo Plan
Sri Lanka

Cindy Biding
Programme Manager (Former)
Drug Advisory Programme - Colombo Plan
Sri Lanka

Winona Pandan
Programme Manager (Former)
Drug Advisory Programme - Colombo Plan
Sri Lanka

Nuwan Wickramasinghe
Senior Graphic Designer (Former)
Drug Advisory Programme - Colombo Plan
Sri Lanka